1. Decedent's Neme (First, Middle, Last)  1. Decedent's Neme (First, Middle, Last)  1. Decedent's Neme (First, Middle, Last)  2. Date of Death Month Dey Ye April 21, 2005	5 16001
	3. Time of Death
Helen Gleason Moore April 21, 2005	8:30 PM
4e Fecility Name (If not institution, give street and number)  4b. City, Town, or Locetton of Deeth  4c. County of Deeth	
Crofton Convalescent Center  Crofton  Anne Ar  5. Social Security Number  6. Sex  7. Age (In yrs. last birthday) Months Days Hours Min. Months Days Hours Min.  (Month, Dey, Year)  9.	Birthplace (State or Foreign Country)
047-18-4087 1 M 2 TF 98 Yrs. Months Days Hours Min. 01/30/1907 Co	onnecticut
Usual Residence of Decedent	10d Inside City Limite
10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits 1 ☑ Yes 2 ☐ No
Maryland Prince Georges Bowie  10e. Street end Number 10g. Citizen of What	t Country?
11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-	American Indian,
1 Never Married 2 Married 1 Ves 2 VNo	Vhite, etc.
3 K Widowed 4 □ Divorced Year or Dates:	
15. Decedent's Education (Specify only highest grade completed)  Elementery/Secondary (0-12) 10  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Factory Worker  16b. Kind of Busing Internati Silver Co	
Elementery/Secondary (0-12) College (1-4or 5+) 10 Factory Worker Silver Co	
17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)	
Patrick Gleason Elizabeth Matthews	
Patrick Gleason Elizabeth Matthews  19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State	te, Zip Code)
Karen Sanda/ Daughter 12203 Westmont Lane Bowie, MD 20715	
20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City	
4□Donation 5□Other (Specify) Huntt Crematory 4/20/20 Waldorf,	MD
21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Fun	eral Home
16000 Annapolis Road Bowie, MD 2071	
23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Approximate Interval Between Onset and Death
Immediate Cause (Final	and alone
disease or condition resulting in death)  Due to (or as a consequence of):	- Cra eag
Sequentially list conditions, if env, leeding to immediate cause Fibral India to management of the sequence of	years
0.	
Sequentially list conditions, if env, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury	years
that initiated events Due to (or as a consequence of):	
d. Diabetes Mellitus	Jeans.
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23b. Did tobacco use contrib	bute to the cause of death?
	☐ Probably 4 ☐ Unknown
24a. Was an autopsy 2- performed?	4b. Were autopsy findings available prior to completion of cause
24a. Was an autopsy performed?	of death?
↑ Tyes 20 No	1 ☐ Yes 2 ☐ No
25. Was case referred to medical 26. Place of Death (Check only one)	(Specify)
examiner? Hospital: Other	эрвину)
examiner?  1 Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  Other: 4 Hoursing Home 5 Residence 6 Other (3 28c. Injury et 28d. Describe how injury occurred)	
examiner?  1   Yes 2   No   Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other: 4   Noursing Home 5   Residence 6   Other (3)	
examiner?    Yes   2 No	or Rural Route Number,
examiner?  1 Yes 22 No  Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA  27. Manner of Death 1 Maturel 5 Pending investigation 3 Suicide 4 Homicide  28e. Date of Injury (Month, Dey Year)  28b. Time of Injury Work?  M 1 Yes 2 No  28d. Describe how injury occurred  Work?  M 1 Yes 2 No  28f. Location (Street and Number of Deuth Injury of D	
examiner?    State   Pending   Pendi	er as stated.
examiner?    Yes 25 No	er as stated. I due to the cause(s)
1   Yes 2   No	er as stated. I due to the cause(s)
examiner?    West   Work   Wor	er as stated. I due to the cause(s)
examiner?  1	er as stated. I due to the cause(s)

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 15 Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month Day **Physician** 25, 8:05pm <sup>™</sup> 2005 April Ercelle Saunders Miller /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Wilson Health Care Center Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🗓 F 83 1921 Virginia 227-14-9332 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits in then "naturel", or Items 23a or 28e-f show 1XYes 2 No Directo Gaithersburg Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 301 Russell Avenue 20877 United States Funeral 72 hours after death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 21 No Specify: Specify: þ 3 ☐ Widowed 4 ☒ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Government Research Secretary other 1 freumetic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If item 27 Is marked oth any injury or other treumetic event Grace Ercelle Cottrell Alwyn D. Saunders 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Patricia Anne Miller (Daughter) 1381 Carolyn Drive, NE, Atlanta, GA 30329 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State \* 4 □ Donation 5 □ Other (Specify) Metropolitan Crematory 4/26/05 Alexandria, Virginia 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Drive Gaithersburg, MD 20877 21. Signature of Funeral Service Licensee let H. Dels 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one of use on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Arterioselesotre cardioviscular desesse Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence on. death certificate be executed burial-tran Due to (or as a consequence of): attending physician Physician/Medical use as the IF FFMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown s been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 Esterarthrete certificate 1 Yes 2 No or Attending Physicien: 25. Was case referred to medical examiner?
1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 V Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) ctor: After this 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after de To the Funerel Directo completely filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital 11 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) V. Robert Dirsch kan leed 004115

State

Registrar

31. Date filed (Month, Day, Year) APR 2 7 2005



30. Name and address of person who completed cause of death (Item 234) (Type, Print) 201 PUSSELL AVENUE

Baltimore, Maryland 21215-0036

P.O.

Division of Vital Records,

			T load	State of M			artment of			•	giene	h o o s		
			1 - For State Registrer		•	-	tificate of				Reg. No.	/	)	6003
	Physicia	20	1. Decedent's Name (First, Middle,	Last)						2. Date of De	ath Day	y Yea	r	Time of Death
	/Medic		Margaret R.					- Land	( D	April		2005		0:55A M
	Examin	er	4a. Facility Name (If not institution,		9r)		4b. City, Town,					County of De	iath	
	Funeral		5348 Dunteac 5. Social Security Number	6. Sex 7. A	Age (In yrs. I	ast birthday)	Ellico	r If Under		8. Date of Bir (Month, Da		loward 9. B	irthplace (	State or Foreign
	Director		161-05-3253	1 ☐ M 2 🕅 F	87	Yrs.	Months Days	Hours	Min.	Aug 10	, 19	17 Pe	$rac{nnsy1}{nnsy1}$	vania
	put &		Usual Residence of Decedent  10a, State 10b, County		10c. City	/. Town or Lo	cation						10d In	side City Limits
	daryla f sho	ō	,	3										☐Yes 2XNo
	r 28e-	Director	Maryland Howard 10e. Street and Number	1		icott	10f. Zip Code				10g. Cit	izen of What (	Country?	
	th with	ai D	5348 Dunteachin	Drive			21043				USA			
	ems er m	ıner	11. Marital Status	12. Was Deceder Armed Forces	s?	S. 13.	Was Decedent of f Yes, specify Cu	Hispanic Ori	gin? (Spe	cify Yes or No Rican, etc.)	)·	14. Race - An Black, Wi		dian,
36	s afte	y Fu	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	ed 1 ☐ Yes 2X If Yes, Give Year or Dates			1 ☐ Yes 2 <b>X</b> ⊇No	Specify:				Specify: T.I	hite	
21215-0036	filed within 72 hours after death with the Maryland Hygiene ther than "natural", or Rems 23e or 28e-f show out, the Medical Examination and the notified at	Completed by Funeral	15. Decedent	s Education		16a. Dece	dent's Usual Occi	upation			16b. K	ind of Busines		
215	hin 72 3. 9n "na Medii	plet	(Specify only highest Elementary/Secondary (0-12)	college (1-40	or 5+)	(Give lite.	kind of work don OO NOT use retii	e du <i>ring</i> mosi ed)	t of workin	1g				
2	ad wit	Con	12		,	Secre	tary					nsport	ation	1
Maryland	be fill tal Hy od oth	Be	17. Father's Name (First, Middle, L	ast)						(First, Middle evine	, Maiden	Sumame)		
2	hould d Mer marke metic	Z.	James J. Ryan  19a. Informant's Name/Relationsh	in (Type Print)		19h Mailir	ng Address (Stree				er City o	r Town State	Zin Code	<u> </u>
<u>⊠</u>	nd 2 s lith an 27 Is i		Dennis J. Nella				Dunteach							"
ē,	s 1 ar f Hea item		20a. Method of Disposition		20b. P	-0.0	sition (Name of natory or other pi		April			cation - City		tate
E	Page nent o int: If iry or		1 ☐ Burial 2 ☐ Cremation 1 ☐ Donation 5 ☐ Other (Sp		(e		el Crema	1	200		0de	nton,	Mary1	Land
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Items 23e or 28e-1 show entry or other treumetic event, the Medical Examinat must be notified at Once.		21. Signature of Funeral Service L	icensee		GO.	Name and Add	ress of Facilit	y ation	Servi	ce	P.O. B	ox 78	34
	20729		Beverly 7.	Hello		251 Be	verly L	Hecki	rotte	. P.A.	Cla	rksvil	1e, M	1D 21029
			23a. Part1. Enter the disease, or shock, or heart failure. List of	only one cause on each	n line.		er the mode of dy	ing, such as	cardiac oi	respiratory a	rrest,		Inter	roximate val Between et and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	Stro									
	Examiner			10) 0) eud	as a consequ	uence or):								
		Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or a	as a consequ	uence of):								
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60,	ate be executed hysician and the burial-transit	cai Examiner	resulting in death) Last	Due to (or a	as a consequ	uence of);								
68760,	physin physin the b			d									-	
Box 6	death certifica e attending phy of for use as th	J/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom								23d. Date of c	delivery	
Ď	0 0 0	icia	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant	at time of de		Ectopic pregnan Other (specify)	cy				Month	Day	Year
P.O.	es that the death igned by the atte be detached for	Physician/Med	9 🗆 Unknown	9∐ Unknown	-					The state of				. ( .   .   .   .   .
	The law requires that the ste has been signed by the bage 2 should be detache	by	Part II. Other significant conditio	as contributing to death	n but not resi	ulting in the u	nderlying cause g	jiven in Part I.	*	1		ise contribute ŽNo 3□.		4 Unknown
Records,	w requir been si should	Completed								24a. Was				
Rec	The law cate has page 2 s	mpi								auto	psy ormed?	prior to	o completion	ndings available on of cause of
tal		ø	25. Was case referred to medical					26 Place	of Death	1 ☐ Yes (Check only		1 🗆 Y	es 2 n	No
of Vital	Physicien: rthis certific ral director,	To B	examiner? 1 ☐ Yes 2 🎇 No	Hospital: 1 Inpa	atient 2	ER/Outpatier	nt 3□ DOA	thor				6 □Other (Sp	pecify)	
П	ng Pt		27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Ir (Month, L	njury Day Year)	28b. Time of Injury	W			8d. Describe	how injur	y occurred		
Sio	Attending r death. ector: After y the fune	icati	2 Accident investig	ation of he	Intione At he			]Yes 2□	-	19f Location	Straat on	nd Number or	Oum I Oout	ta Numbar
Division	Jor A after Direc	Certification:	4 Homicide determi	ned 286. Place of building,	etc. (Specif)	y)	eet, factory, office	Ð		City or To			nurar nour	te reumber,
	To the Hospitel or Attending Physicien: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.		29a. Certifier tX Certifying	g Physicien: To the be	st of my kno	wledge, deat	n occurred at the	time, date an	nd place, a	nd due to the	cause(s)	and manner	as stated.	
	he Ho in 24 in Fu pletel	edicai	(Check only 2 Medicel I	Exeminer: On the basis and manner		tion and/or in	vestigation, in my	opinion, dea	ith occurre	d at the time,	date and	d place, and d	ue to the c	ause(s)
	To T To 1	Σ	29b. Signature and title of certifier	200			29c. Lice	nse number				te signed (Mo		Year)
	011		La (	Irolly				1/1	/		Apri	11 27,	2005	
(	2.0		30. Name and address of person (	vno completed cause o				3/206	, 5	n /	/	20044	,	
	Sta	ite	31. Date filed (Month, Day, Year)	32. F Sgi	istrar's Signa	ture	Prada		, ,	100		2.07.7		-
	Registr	ar	APK 2 (	> 2003	wes.	15 /	0542							

			1 - For State Registrar	State of Maryla			of Hea	Ith and M	Mental Hyg		2005	16001
_	ysicia ledic		1. Decedent's Name (First, Middle, Las  JEWEL JOSEPHII	NE ORLOSKI					2. Date of Dea Month April	Day 2 I	2005	3. Time of Death 5:30 A M
Exa Fune	amine eral		4a. Facility Name (If not institution, give Mariner of Great  5. Social Security Number 6. Second Security Number	er Laurel	s. last birthday)	Lau If Under	rel	Under 24 Hrs.	8 Date of Birth	Pr	County of Death	lano (Stato or Foreign
Direc			219.88.5387   1	M 2⊠F 66	Yrs. City, Town or Le		Duys   11	OUTS WILL.	July 29	, 1	938 Wash	ington, DC
ith the Mar	De L'ORIGINA	Director	Maryland Prince (		Beltsvi	10f. Zip (		-	1	l0g. Citi	izen of What Coun	1 ☑ Yes 2 ☐ No htry?
I're, INIAT YIZITIQ Z IZ IS-UUSO s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene 'naturel', or Items 23s or 28e-f show	EXAMINET MUSIC	by Funeral Director	3509 Susquehana D  11. Marital Status  1 XNever Married 2 Married 3 Widowed 4 Divorced	rive  12. Was Decedent Ever in Armed Forces?  1 ☐ Yes 2 [X]No If Yes, Give Year or Dates:		Was Decede If Yes, speci	ent of Hispar fy Cuban, N	nic Origin? (Splexican, Puerto	pecify Yes or No- Decify Yes or No- Decify Yes or No-		SA  14. Race - Americ Black, White,  Specify: Whi	etc.
Mary laring 6 16 15-0030 nd 2 should be filed within 72 hours alf lih and Mental Hygiene. 27 le marked other than "naturel", or	ne Medical	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	16a. Dece (Give life.		Occupation k done durin e retired)	g most of worl	king		ind of Business/Ind	
aryiaria 2 should be filed and Mental Hygie marked other	atic event,	To Be Co	17. Father's Name (First, Middle, Last)  John A.E. Orloski		NOI	ie			e (First, Middle, i	Maiden		and the second s
ore, Mary	or other treume	3	19a. Informant's Name/Relationship (7)  Mary Jane Phillip  20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ 1	s/Sister 20b.		Grace	field	Rd, #2	218. Sil	ver	Spring	MD 20904
permit. Pages 1 as Department of Hez Important: If item	ony injury		*4 □ Donation 5 □ Other (Specify, 21. Signature of Funeral Service Ligan	Ga		2. Name and	Address of	Facility Hir	nes-Rinal	ldi	Funeral	pring, MD Home , MD 2090
Pnysici /Medi			23a. Part1. Enter the disease, or comp shock, or heart affure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Aspiration l	ath. Do not ent Pneumon	er the mode						Approximate Interval Between Onset and Death
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the death certific	2	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome of pregr 1 Live birth 2 Fel 4 Pregnant at time of 9 Unknown	tal death 3	Ectopic pre				2	23d. Date of delive Month	ry Day Year
w requires that been signed by	8 .	à	Part II. Other significant conditions co Hypertension	ntributing to death but not re	sulting in the u	nderlying ca	use given in	Part I.			se contribute to the	e cause of death? ably 4 □Unknown
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Phy Phy	Ē	0	25. Was case referred to medical examiner?  1  Yes  2 No  27. Manner of Death 1 Natural  5 Pending 2 Accident investigation	Hospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury		-	Nursing Ho	h (Check only only only only only only only only	nce 6	3 □Other (Specity, y occurred	)
9	i ka ii pe	Certification;	3 Surcide 6 Could not be 4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec	ity)				City or Town	, State)		
To the Hospitel c within 24 hours af To the Funerel D	included by	Medical	29a. Certifier (Check only one)  1	sician: To the best of my kn ner: On the basis of examin and manner stated.	owledge, death ation and/or in	vestigation, i	n my opinior	n, death occur	red at the time, da	ate and	place, and due to	the cause(s)
5 ¥ 5 €	110			Ceuo AH	,	} , D-	License nur –4258(				il 25, 20	
	State	e	Parmjit Singh A		32 Anna	polis	Road,	Suite	#13, B1	ade	nsburg, l	MD 20710

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month 0835AM JAMES ETERSON APRIL 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 4174 THE HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. 1968 HOPKUS SIMMIT Birthplace (State or Foreign Country) New York 5. Social Security Number 7. Age (In yrs. last birthday) Days Hours 10 M 2□ F 099-58-7941 36 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21001 25 Chesapeake Court United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ▼Yes 2 □ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: Black Year or Dates: unknown 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Compation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Transporter Supervisor Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) James Peterson Sarah Bulls 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shavon Peterson / wife 25 Chesapeake Court, Aberdeen, Maryland 21001 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State Church in the Lord Jesus Church in the Lord Jesus Christ Apostolic Faith 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 5/2/05 Hartsville, SC 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) day EmBilui ULMONAR. Due to (or as a consequence of) ! mont BURKITT' Limpitoma Sequentially list conditions, if any local to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) 4 Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an 1 Yes 2 No 26. Place of Death (Check only one) examiner? Hospital: 1 Anpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \( \text{Specify} \) 1 ☐ Yes 2 No

**Physician** /Medical Examiner The law requires that the death certificate be executed

the

certificate has

this

After

Director:

within 24 hours at To the Funaral D completely filled it

Medical

State

Hospital or Attending Physician:

**Physician** 

**Examiner** 

**Funeral** 

Director

ral, or itams 23a or 28e-f show Exeminer must be nutified at

"natural"

Hygiene.

or other traumatic event, the Madical

Is marked other

permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Importent: If item 27 Is marked othe any injury or other transmit

Directo

Funerai

Completed by

Be

2

with the Maryland

filed within 72 hours after death

Baltimore, Maryland 21215-0036

/Medical

Examiner attending physician for use as the buria Physician/Medical þ Be Completed P Certification:

Division of Vital Records, P.O. Box 68760,

IF FEMALE: 23b. Was decedent pregnant

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical

27. Manner of Death

1 Natural

2 Accident

3 Suicide

29a. Certifie

4 Homicide

(Check only

5 Pending

investigation 6 Could not be determined 28a. Date of Injury (Month, Day Year) 28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

APRIL 24

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

31. Date filed (Manth Ray 2 ear)

WEN MA,

29c. License number

ST

Res - 000

BALTIMURE

29d. Date signed (Month, Day, Year)

2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

2005

600 M. WOLFE

32/Registrar's Signature

Registrar DHMH 17 Rev 1/2001

96×

		1	For State Registrar	State o	f Marylan	•	rtment of H			giene leg. No. 200	5 15006
			Decedent's Name (First, Middle, Last	t)					2. Date of Dea	th	3. Time of Death
	Physicia /Medic			Rozelle	Lydia	Phe1ps			April	27, 2005	4:20 A. M
	Examin		4a. Facility Name (If not institution, give					Location of Death		4c. County of De	
			Crofton Convale  5. Social Security Number 6. S		7. Age (In yrs. I	ast hirthday)	If Under 1 Year	ofton If Under 24 Hrs.	8. Date of Birth		Sirthplace (State or Foreign Country)
	Funeral Director			_M 2 <b>∑</b> F	81	Yrs.	Months Days	Hours Min.	(Month, Day Aug. 26		country) ash. DC
	ט		Usual Residence of Decedent			, Town or Lo			, <b>Q</b>		10d. Inside City Limits
	arylar show	2	10a. State 10b. County				cation				1 A Yes 2 No
	28a-1	Director	Md. Prince Go	eorges		Bowie	10f. Zip Code			10g. Citizen of What	Country?
	3e or		12319 Stonehav	en Lane			·	0715		USA	
	death	Funeral	11. Marital Status		edent Ever in U.	S. 13.	Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (Sp	Decify Yes or No-	14. Race - Ar Black, Wi	merican Indian,
9	or ite		1 Never Married 2 Married	1 ☐ Yes If Yes, Gir	2 🔀 No		□ Yes 2½ No	Specify:	, , , , , , , , , , , , , , , , , , , ,	Specify: W	
Ö	hours turel',	ed by	3 😾 Widowed 4 □ Divorced  15. Decedent's Ec	Year or D	ates:	16a Decer	lent's Usual Occupa	ation		16b. Kind of Busines	ss/Industry
r.	n "na'	Completed	(Specify only highest gra		40151)	(Give	kind of work done of OO NOT use retired	turing most of worl	king		,
212	d with giene	mo	Elementary/Secondary (0-12)	College (	-401 5+)		Homemake	er		Own home	
g	be filed within 72 hours after death with the Maryland bygiene. Bygiene. Bygiene. dother then "naturel", or items 23e or 28e-f show other then "naturel", or items 23e or 28e-f show event, the Medical Examinar must be notified at	Be C	17. Father's Name (First, Middle, Last)							Maiden Sumame)	
yla	ould to	P_			Trail	40h Mailte	- Address (Chrost		e Riley	c City or Tourn State	Zio Code)
Maryland 21215-0036	d 2 sh th and 7 Is rr treum		19a. Informant's Name/Relationship (							r, City or Town, State 1and 2071	7
<u>ئ</u>	Heali Heali tem 2 other		Michael R. Phelp 20a. Method of Disposition	s - <u>501</u>	20b. P	lace of Dispo	sition (Name of natory or other place		Date Tidi	20c. Location - City	
OE .	Pages ent of nt: If i		1 ☐ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specif	Removal from	State		an Cremat		30 <b>-</b> 05	Alexandria	, VA
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Menth Hygiene.  Importent: If item 27 is marked other then "naturel; or items 23e or 28a-f show emprortent: If item 27 is marked other then "naturel; or items 25e or 28a-f show empty injury or other treumatic event, the Medical Examinating must be rediffied at once.		21. Signature of Funeral Service in	ss of Facility Be	eall Fund	eral Home ie, Maryla	and 20715				
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that o	aused the death						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	(	gode	ac i	Arryltan	Ma			Onset and Death
	/Medical Examiner		resulting in death)	Due to	(or as a conseq	uence of):					
н	LAGIIIIICI	7	Sequentially list conditions,	b. Due to	(or as a conseq	uence off:					
	I I Insit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		(0. 00 - 00 - 00 - 00						
ó	an and rial-tra	Еха	that initiated events resulting in death) Last	Due to	(or as a conseq	uence of):					
8760,	icate be executed physician and s the burial-transit	dical		_ d							
9	certificate be executed nding physician and use as the burial-transit	Med	IF FEMALE:	230 If yes ou	tcome of pregna	ancy				22d Data of	deliner
Вох	atter for u	by Physician/Med	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live I	pirth 2 ∏Feta nant at time of d	I death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	Day Year
o.	that the de ed by the detached	ysic	1 Yes 2 No 9 Unknown	9□ Unkn							
s, P	s that pned b	y PI	Part II. Other significant conditions	contributing to d	eath but not res	ulting in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use contribute	to the cause of death?
ords	w requires that s been signed t should be det		Demen	<u>a</u>	1.4				1 🗆 Y	′es 2 No 3 ☐	Probably 4 Ill-Inknown
Division of Vital Record	e la has	ompleted	failue	101	topic				24a. Was autop perfor	rmed? prior death	autopsy findings available to completion of cause of ?  'es 2 \sum No
/ita	ıysician: Th is certificate director, pag	BeC	25. Was case referred to medical examiner?				04		th (Check only o	ne)	
<b>d</b>	90 :=	٦.	1 Yes 27 No 27. Manner of Death	Hospital: 1  28a. Date		ER/Outpatier 28b. Time o		Nursing H		dence 6 Other (S	pecify)
CO	ding h. After funer	tlon	Natural 5 Pending 2 Accident investigatio	(Mor	th, Day Year)	Injury	Wor		200. 200000		
ivisi	of or Attending Phy safter death. I Director; After this d in by the funeral c	Certification:	3 Suicide 6 Could not be determined	e 28e. Place	of Injury - At h	ome, farm. sti fy)	eet, factory, office		28f. Location (S City or Tox	Street and Number or vn, State)	Rural Route Number,
	To the Hospitel or Atte within 24 hours after de To the Funerel Directo completely filled in by th		20- C-14 AA		had started	nulades de l	h annuar d - 1 1 1	no date and -t-	and due to the	20100/p\ and	as stated
	Hospitel 24 hours a Funerel I etely filled	edical	29a. Certifier 1 ☐ (Certifying PI (Check only 2 ☐ Medical Examone)	miner: On the b	e best of my kno lasis of examina liner stated.	wiedge, deat ation and/or in	n occurred at the tir vestigation, in my o	ne, date and place pinion, death occu	r, and due to the time, i	cause(s) and manner date and place, and c	due to the cause(s)
	within To the To the Somple	Me	29b. Signature and tilte of certifier	-			29c. Licens	e number		29d. Date signed (Mo	onth, Day, Year)
)							D	5702			7-05
L	-(3)		30. Name and der ss of person who	completed cau			Print)				s, mp. 21401
1	0		ADITYA CHO	PRA	M.D.	(ODO)	Ridgeli	HUP. SH	e. 231 H	nnapolis	5, m12. 21401
	Sta Regist		APR 2 8 2005	Ken	Registrar's Signa	Apos	w	_			
			711100		1000FL 5FL	-					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrat Certificate of Death Reg. No. 2. Date of Death 1 Decedent's Name (First, Middle, Last) Day Year **Physician** 4:45 AM 2005 John Knight Parlett, Sr. May /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 38250 New Market Turner Rd. Mechanicsville St. Mary's If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** 1⊠M 2□F 68 Yrs. Director 217-34-1718 February 1,1937 Maryland Usual Residence of Decedent 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Show 10a. State r than "natural", or items 23a or 28a-f shor The McCleal Exeminatings the hollified at 1 ☐ Yes 21 No Maryland St. Mary's Mechanicsville Direct 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 38250 New Market Turner Rd. 20659 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'na any injury or other traumatic event College (1-4or 5+) Elementary/Secondary (0-12) Farmer Agriculture 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lawrence Linthicum Parlett Lucy Louise Fowler 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Catherine A. Parlett Wife P.O. Box 25 Charlotte Hall, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) May 4, 2005 Metropolitan Crematory Alexandria, Virginia 21. Signature of Funeral Service Licer 22. Name and Address of Facility
MattingTey—Gardiner FuneralHome, P.A.
P.U. Box 270 Leonardtown, MD 20050 premer uchae ( 23a. Part 1 Enter the disease, or como cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Verc disease or condition resulting in death) /Medical Due to (or as a consequence of) obstactive pulmoner Examiner Sequentially list conditions, I any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed burial-transit that initiated events attending physician and resulting in death) Last Due to (or as a consequence of) Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ as thma 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed this certificate 1 Yes 2 No Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Cther: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 2 the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; After 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation after death 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 036206 5/02/05 ree Notth Rd Hollywood no 20636 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MEGITA

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

gistrar's Signature

2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 11 5 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician Edward 02 10:24 Pussler MAY 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Hospital Leonardtown St. Mary's If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 MM 2 □ F Director 213-38-2633 91 April 5,1914 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits la or 28e-f show I be notified at 1 ☐ Yes 2 RNo Directo Maryland St. Mary's Leonardtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a 21692 Point Lookout Road United States 20650 Funeral ir than "netural", or Items The Medical Examination 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status PYes 2 No 1941− fYes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Completed by Specify: White 3 Widowed 4 Divorced 1945 Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 8 Farmer 12 should be filed v h and Mental Hygie 7 is marked other t Agriculture other treumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Nicholas Pussler Mary Louise Dean 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 Malcolm Morris / Nephew 21692 Point Lookout Road, Leonardtown, MD 20650 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ■ Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Andrew's Cemetery 5-6-2005 California, Maryland 21. Signature of Funeral Septice Libensee

Edward N. Brinsfield. Jr. 22. Name and Address of Facility Brinsfield Funeral Home, P.A. M00052 22955 Hollywood Road, Leonardtown, MD 20650-0279 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death n tracere Immediate Cause (Final disease or condition resulting in death) **Physician** 1414 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examiner The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 attending physician Physiclan/Medical as the use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown 9 Unknown څ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably ★ Unknown Completed 24a. Was an autopsy performed? 1 Yes 25 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 25 No of Vital Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 K ER/Outpatient 1 ☐ Yes 2 ☐ **Y**6 3 DOA this 27. Mapner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division or Attending Injury Natural 5 Pending 1 ☐ Yes 2 ☐ No after death Director: 2 Accident investigation filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funerel I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ST. MARYS HOSPITAL P.O. BOX 527 LEONARDTOWN MD MARTIN MCGREIVY MAY 0 4 2005 State Registrar

			1 - For State Registrar	State of	Maryland		artmer rtificat			nd Me	ental Hygi	iene	005	1600
	Physic /Medi		1. Decedent's Name (First, Middle, La:  Janelle Marie Pe	nnington			-				2. Date of Death Month April 2	Day	Year	3. Time of Death
	Examii Funeral	ner	4a. Facility Name (If not institution, give  Holy Cross Hospi  5. Social Security Number  6. S	tal	er) Age (In yrs. Id	,,		Silve	er Spr If Under 24 Hours	ing	3. Date of Birth	Mon	t gome:	
	Director		227-48-9315 Usual Residence of Decedent 10a. State 10b. County		10c City	67 <sup>Yrs.</sup>	cation				Mar 7,			rginia
	er death with the Marylan tems 23e or 28e-f show net must be mailfied at	Director	Virginia Orange  10e. Street and Number		Toc. Oily		ust (		:		10	g. Citizen	of What Cou	10d. Inside City Limits 1 ☐ Yes 2 ☒ No untry?
9800	or i	by Funeral	9454 Barnes Rd  11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Decede Armed Force 1 Tyes 2 If Yes, Give Year or Date	es? ₹ No					n? (Speci Puerto Ri	fy Yes or No- can, etc.)	1	Race - Amer Black, White ecify:	
Maryland 21215-0036	within ane. than '	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12) 12		or 5+)	life. I	dent's Usua kind of wo DO NOT us emake	rk done d se retired)	urina most a	of working	1		f Business/li	
ryland ;	should be filed nd Mental Hygis marked other umetic event, II	To Be C	17. Father's Name (First, Middle, Last) Thomas Lee Watso	n	,				Marga	arett	First, Middle, M	aiden Sun se Sh	elton	
ď	and 2 lealth a m 27 is		19a. Informant's Name/Relationship (7  David S. Penning  20a. Method of Disposition	ton/Son		2124	Gate	wood	P1, S		Route Number, er Sprin	n M		3
Baltimore,	permit. Pages 1 Depertment of H Importent: If ite any injury or ot		1 XBurial 2 Cremation 3 C 4 Donation 5 Other (Specify 21. Signature of Funeral Service Ligen	<i>'</i> )	110	22	Nati . Name an	onal	Cem A	Ever1	29, 200 y Funer	cal H	ome	e, VA
	Pnysician /Medical		23a. Part 1. Enter the disease, on comp shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a	1042	Do not ente	er the mod	e of dying						Approximate Interval Between Onset and Death days
	death certificate be executed as a strengting physician and increase as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate caus. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Last	b		westi	ve He	art	FAilur	ce				days
	death certif e attending id for use as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		2 Fetal of at time of dea	death 3	Ectopic pro						Date of delive	ery Day Year
7	The law requires that the tte has been signed by th page 2 should be detache		Part II. Other significent conditions co	ontributing to death	but not result	ting in the un	nderlying ca	ause giver	n in Part I.			2 No		he cause of death?
ai necc		Completed	OF Was and a street to a street							_		ed? □ No	prior to co death?	opsy findings available impletion of cause of
DIVISION OF VITAL RECORDS,	Phys rthis raldii	atlon: To Be	25. Was case referred to medical examiner?  1  Yes  X No  27. Manner of Death  1 Natural 5 Pending 2  Accident investigation			R/Outpatient 28b. Time of Injury		A Other 8c. Injury Work	4 🗌 Nursi	ng Home	5 Residen  5 Residen  d. Describe how	сө 6 □С		59)
DIVIS	itel or Attend rs after death el Director: /	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of	njury - At hom etc. (Specify)	ie, farm, stre	eet, factory	, office		28f	Location (Stre City or Town,		mber or Rura	al Route Number,
	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the funerel	Medical	29a. Certifier (Check only one)  1 Certifying Phy 2 Medical Exam	vsician: To the be iner: On the basis and manner	or examination	ledge, death on and/or inv	estigation,	in my opi	nion, death o	olace, and occurred	at the time, date	e and place	e, and due to	the cause(s)
ļ	¥ 2 8 € 1 8 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	4	29b-Strains and title of certifier		ug.		D	License	number 87	-	290	-	ned (Month,	* * * * * * * * * * * * * * * * * * * *
	1		30. Name and address of person who c	12 PO	BOX	838	190	ga	ilher	rslon	ngn	ND.	208	83
e P.	Sta Registr	te ar	31. Date filed (Month, Day, Year) APR 2 7 20	105 32 Regis	strar's Signatu	Te And	ales							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 0200 M MARY QUIRK may 2 2005 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Washington County Hospital Hagerstown Washington If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Min. March 5, 19 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🗓 F Yrs 235-12-1684 89 1916 Director Maryland Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Worle r than "natural", or itema 23s or 28s-f show the Medical Examiner must be collified at 1 ☐ Yes 2¥ No Funeral Director Washington Hagerstown Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21740 9946 Downsville Pike U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. e filed within 72 hours after of Hygiene. 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: White Completed by 3X☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 8 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be fill timent of Health and Mental Hitant: if item 27 is marked oth jury or other traumatic even Be Elmer Summers Nola Elizabeth Moore 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9 Public Square, Hagerstown, Maryland 21740 Guardian Charlene K. Lloyd 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any Injury or once. Rose Hill Cemetery 05-04-05 Hagerstown, Maryland 4 □ Donation 5 □ Other (Specify) Andrew K. Coffman Funeral Home, Inc. 21. Signature of Funeral Service Licenses 40 East Antietam Street, Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician Andstenn2 - mi Cardice disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Scharica Condio Vanada temos The Sequentially list conditions, if any, leading to immediate causs. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 Other (specify) ed by the a 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Marketa Coronas Autor 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed properturian Morotaguilin 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No. 1 Yes 2 - No Division of Vital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ENOutpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No this After thi funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident I Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after To the Funeral Dire 4 Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D(8019 CAU MO MAY 3 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21745 MO MILL ST MAGERSTOWN MD DATTA 340 31. Date filed (Month Ray, Year) 3 2005 32. Régistrar's Signature State Registrar

Registrar

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	s i and 2 should be filed within 72 hours after deeth with the Maryland Health and Mental Hygiene tem 27 is marked other than "natural", or items 23a or 28a-f show other treumaild event, the Modical Examinat must be notified at	Funeral	25753 Vista R	oad 12. Was Decedent B	ver in 11 S	13 \	206		necify Ves or No-	United	American Ir	
	Her de	Ľ.	11. Marital Status  1 ☐ Never Married 2  Married	Armed Forces?		10.1	Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puert	o Rican, etc.)		White, etc.	
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Ë	. Pa tmen tent: jury		`4 □Donation 5 □ Other (Speci		Bang		neran Cem			Portland		
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 Department of Health a Importent: If Item 27 is any injury or other treu		21. Signal Suneral Service Lice	Du (	>			ess of FacilitBri				
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	Physician		Immediate Cause (Final disease or condition resulting in death)	a. WE /A)	74110	- 13	REAST	CANCE	TR			CARS
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P.O.	that the ed by the detache	hys	9 Unknown	9□ Unknown								
_	s tha	by P	Part II. Other significant conditions	contributing to death be	ut not resultia	ng in the u	nderlying cause gr	ven in Part I.	23e. Did tol	pacco use contrib	ute to the ca	ause of death?
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RA n o	ng Pl fter th		27. Manner of Death  1 ☑Natural 5 ☐ Pending	28a. Date of Injui (Month, Da)	Year) 28	3b. Time of Injury	Wo	ry at rk?	28d. Describe ho	w injury occurred	I	
BARBARA Division of	eath. or: A	Certification:	2 Accident investigation	20				Yes 2□No				
BAI	or Att	ŧ	3 Suicide 6 Could not l 4 Homicide determined	28e. Place of Inju- building, etc	ury - At home c. (Specify)	e, farm, str	eet, factory, office		28f. Location (St City or Town	reet and Number n, State)	or Rural Ro	ute Number,
	To the Hospitel or Attending Physicien: The law requires tha within 24 hours after death.  To the Funerel Director: After this certificate has been signed completely filled in by the funeral director, page 2 should be de								<u> </u>			
	Hose 24 ho Fune Fune	edical	29a. Certifier 1 Certifying P (Check only 2 Medical Exa	hysician: To the best of miner: On the basis of and manner sta	examination	and/or in	occurred at the tr vestigation, in my	me, date and place opinion, death occu	rred at the time, d	ause(s) and manr ate and place, an	er as stated d due to the	l. cause(s)
	the thin 2 the omple	Mec	29b. Signature and title of certifier	and manner sta	ned.		29c. Licens	se number	2	9d. Date signed (	Month, Day,	Year)
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	M		30. Name and address of person who	Completed sauce of d				- 10				
(	V.							VIJOOD AT	20626			
	Sta	ite	DR. RAJBINDER GI 31. Date filed (Month, Day, Year)	22 Basine	arta Cionatur			YWOOD, MD	ZU036			
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2005 Year April 29, **Physician** Robert Stephen Reed 7:18 p.m. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 42838 Higgs Lane Hollywood St. Mary's If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) Feb. 6, 1948 Washington, DC 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1₩ 2□ F 57 Yrs. 557-66-5448 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, the Medical Examinat must be invitited at 1 TYes 2 No Director St. Mary's Hollywood Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20636 USA 42838 Higgs Lane death Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Iter any Injury or other traumatic event, the Medical Examination. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White Baltimore, Maryland 21215-0036 Specify þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Sales Auto 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Doris Lang ပ Robert Reed 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Gloria Reed/wife 42838 Higgs Lane, Hollywood, MD 20636 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Southern Memory of other place) Gardens Burial 2 Cremation 3 Removal from State May 3, 2005 Dunkirk, MD \* 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Trinstield-Echols Funeral Home, 21. Signature of Funeral Service Licens P.A., 30195 Three Notch Rd., Charlotte Hall, MD Approximate 20622 Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Concestive disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequen of): Examiner burial-transit Cer-COSONGY Due to (or as a cons-ruence of): attending physician Box 68760 Physician/Medical as the b IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) P.0. 9☐ Unknown 9 Dloknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, insulin seguisir 1 Tyes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? FC 24a. Was an autopsy performed? res 2 No 1 Yes 2 No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5X Residence 6 Other (Specify) P 1 ☐ Yes 2 X No 28b. Time of 28c, Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifie 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KAE T, AUNG, 24435 MERVELL MD 20636 DEAN RD. HOLLYWOOD 31 Date filed (Month gistrar's Signature State 3 2005 Registrar

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Registrar DHMH 17 Rev 1/2001

State

APR 2 8 2005

31. Date filed

2. Registrar's Signature

Joseph T. Shorter 05-2653 DOS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

26	53		For 1_ State	State of Ma	ıryland / I		tment of					2005	1001
			Registrar  1. Decedent's Name (First, Middle, Last)		-	Ceru	ilicate of	Deain		2. Date of De	Reg. No. (	1000	3, Time of Death
	Physici	an	JOSEPH TERRANCE							Month	Day	Year 2005	420 a M
	/Medic		4a. Facility Name (If not institution, give				4b. City, Town,	or Location	of Death	April		Ounty of Death	120 4
	Examir	let	Easton Memorial H				Eastor				Т	albot	
	Funeral			-	(In yrs. last bi	irthday)	If Under 1 Year Months Days	If Under	24 Hrs. Min.	8. Date of Bir	th		lace (State or Foreign
	Director		219-70-8452	M 2 F	45	Yrs.	Violitis Days	110013	WIII I.	(Month, Da AUG 29	1959	MARY	LÁND
	pur *		Usual Residence of Decedent  10a. State 10b. County		10c. City, Tow	vn or Loca	ation			<u> </u>		11	0d. Inside City Limits
	sho	ក			•								1 ☐ Yes 2 X No
	1he N 28a-1	Director	MD CAROLI	.NE	P1	RESTO	10f. Zip Code				10g. Citize	en of What Coun	itry?
	with with		3209 MEADOWS CO	URT			216	555				USA	
	72 hours after death with the Maryland naturel', or Items 23a or 28a-1 show dicel Exprimer mast ke notified at	Funerai	11. Marital Status	12. Was Decedent 8	ver in U.S.	13. Wa	as Decedent of	Hispanic Or	igin? (Sp	ecify Yes or No Rican, etc.)	- 14	4. Race - Americ	
9	after or Ite		1 Never Married 2X Married	Armed Forces? 1 ☐ Yes 2 X N If Yes, Give	o		Tes, specily Cu ⊒Yes 2∭2 No			rican, etc.)		Black, White, 6	ITE
21215-0036	irel',	d by	3 Widowed 4 Divorced	Year or Dates:	1								
5-	natu	Completed	15. Decedent's Edu (Specify only highest grad		16a	Give ki	nt's Usual Occu nd of work done O NOT use retir	ipation a during mos	st of work	ing	16b. Kind	d of Business/Inc	lustry
12	within ene. then "	dmo	Elementary/Secondary (0-12)	College (1-4or 5	+)		JCKER	50)			A CI	RICULTUR	T.
<b>q</b> 5	filed Hygi Sther ant, I	0	17. Father's Name (First, Middle, Last)	U			CKEK	18. Moth	er's Name	e (First, Middle,			.Б.
an	lid be lental ked c	To B	DUKE E. SHORTER					OM	. O A	EWELL			
Maryland	s 1 and 2 should be f Health and Mental item 27 is marked t other treumetic ev	_	19a. Informant's Name/Relationship (Ty	rpe, Print)	191	b. Mailing	Address (Stree	t and Numb	er or Run	al Route Numb	er, City or	Town, State, Zip	Code)
	1 and 2 Health a tem 27 is		TONI SHORTER/WIFE	E		3209	MEADOWS	COUR	т, Р	RESTON,			
ore	m O		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F	Removal from State	20b. Place o	of Disposit ery, crema	tion (Name of itory or other pl	асө)		Date	20c. Loc	ation - City or To	wn, State
Ĕ	Pages ment of ent: If it ury or o		' 4 □ Donation 5 □ Other (Specify)	Idinoval Hom Oldio	WOODLA					1-2005		CON, MAR	
Baltimore,	permit. Page Department of Importent: If eny injury or once.		21. Signature of Funeral Service Licens	66		FE FE	Name and Addi	ess of Facili HELFE	NBEI	N & NEW	H MAN	FUNERAL	HOME PA
_	20 = 0 Q		23a. Part 1. Enter the disease, or compl	MERI		-				EASTON		21601	Approximate
			shock, or heart failure. List only o	ne cause on each lir	ιθ.						\		Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a ATHOM			(77 LOH	2VD) a	rion	DIS ST.	772		
	Examiner			Due to (or as	a consequence	or):							
		ē	Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence	of):							
	uted d ansit	Examine	Cause. Enter Underlying Cause (Disease or injury that initiated events	c.									
o,	an an rial-tr		resulting in death) Last		a consequence	of):							
8760,	cate be executed physician and the burial-transit	dlcal		d									
9	requires that the death certificate be executed seen signed by the attending physician and hould be detached for use as the burial-transit	Med	IF FEMALE:										_
Вох	eath certific attending p	Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth	2 🗌 Fetal deat		ctopic pregnan	су			23	3d. Date of delive Month	ory Day Year
0	at the de by the a ntached f	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□ Pregnant at 9□ Unknown	time of death	5[](	Other (specify)						
Δ.	that the ed by		Part II. Other significant conditions co	ntributing to death be	ut not resulting	in the unc	derlying cause g	iven in Part	l.	23e. Did t	obacco us	e contribute to th	e cause of death?
ds,	uires sign ld be	d by								1 🗆 '	Yes 2	No 3 Prob	ably 4 Unknown
COL	w requir been s should	iete						_		24a. Was	an	24b. Were autor	psv findings available
Vital Record	The law ate has b page 2 sh	Completed									rmed?	death	psy findings available inpletion of cause of
tal	icien: Th certificate ector, pag	Ö	25. Was case referred to medical					26. Plac	e of Deat	1 M Yes h (Check only o	2□No	Yes	2□ No
<u>&gt;</u>	Physicien: this certific ral director,	To B	examiner? 1∑ Yes 2 □ No	Hospital:	nt 2 XER/O	outpatient	3□ DOA O	ther				Other (Specify	()
Jou	ig Ph ter thi		27. May er of Death  1 V Natural 5 Pending	28a. Date of Injur (Month, Day	y Year) 28b.	Time of Injury	28c. Inj	ury at ork?	19.5	28d. Describe	how inju <i>r</i> y	occurred	
Sion	uttending death. ctor: Aft y the fun	atic	2 Accident investigation			. ,		□Yes 2□					
Division	l or Attending after death. Director: After I in by the fune	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubul	ury - At home, f c. (Specify)	farm, stree	et, factory, office	•		28f. Location (. City or To	Street and wn, State)	Number or Rura	I Route Number,
Ω	urs al			11-1		-1 -15			1				
	Hospital 24 hours a Funerel D	edicai		rsician: To the best of iner: On the basis of and manner sta	examination a								
	To the Hos within 24 h To the Fur completely	Med	29b. Signature and title of certifier	and mailler Sta			29c. Licer	nse number			29d. Date	signed (Month,	Day, Year)
	⊢≯⊢ŏ		Mayberto Do	Male	im		OCM	Œ			Ap	ril 16,	2005
			30. Name and address of person who c	ompleted cause of d	eath (Item 23a)	) (Type, P							
(	5)		YORGOWS D.K	LOREU			111	Penn S	Stree	et Bali	timor	e, Maryl	Land 21201
8		ate	31. Date filed (Month, Day, Year) 5	32. Registra	ar's Signature	-	A .						
1000	Regist	rair	2 2 2 2 2 2 2 2 2			de propriés .							

			1 - For State Registrar	State of Mar	yland / De		of He	alth and M	ental Hygi	9	6018
	Physicia /Medic	al	Decedent's Name (First, Middle, La:     MARGARET WILLI	S STEVENS		45 63. 7	·		2. Date of Death Month 04/13/	Day Yea	/:30 EWM
	Examine Funeral Director	er	4a. Facility Name (If not institution, given Genesis Elde 5. Social Security Number 216–38–9910	erCare-The	Pines (In yrs. last birthda	Eas	ston	f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, MAY 24	4c. County of De  Talk  9. B  Year)  MA	
	e Maryland 8e-f show	Director		LBOT	loc. City, Town or	Location					10d. Inside City Limits
	th with th	al Dire	10e. Street and Number 610 DUTCHMAN S	LANE		10f. Zip (	2160	1	10	g. Citizen of What (	Country? SA
t 036	urs a	by Funeral	11. Marital Status  1 Never Married 2 Married  3X Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 24 No If Yes, Give Year or Dates:	er in U.S. 1	3. Was Decede If Yes, speci 1 ☐ Yes 2		anic Origin? (Spe Mexican, Puerto Specify:	cify Yes or No- Rican, etc.)	14. Race - An Black, Wh Specify: W	
garet 1215-0036	thin 72 ho e. "natur Medical	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ducation ide completed)  College (1-4or 5+)	(G.	cedent's Usual ive kind of work b. DO NOT use	Occupati done du retired)	on ring most of worki	ng 1	6b. Kind of Busines	s/Industry
Stevens, Mare	ould be filed wil Mental Hygien arked other th atic event, II s	Be	11 17. Father's Name (First, Middle, Last)	0		SEAMSTRI		8. Mother's Name		ALTERATI (aiden Sumame)	ONS
evens,	d 2 should th and Mer 7 is marke treumatic	ဥ	CHARLES F. WILL  19a. Informant's Name/Relationship ( ANN STEVENS/DAU	Туре, Print)					l Route Number,	City or Town, State	
Stevanore,	Pages 1 and 3 nent of Health int: If item 27 iry or other tr		20a. Method of Disposition  1 XBurial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specification of the content	Removal from State	20b. Place of Dis cemetery, of		e of ner place)		ate 2	Oc. Location - City of OXFORD,	or Town, State
Baltii	permit. Pag Department Importent: I eny injury o		21. Signature of Funeral Service Licer	nsee		22. Name and	Address	of Facility	C MITHERAL	M DIMEDA	L HOME PA
اء	Pnysician	l l	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	plications that caused the one cause on each line.	ne death. Do not	enter the mode	of dying,	such as cardiac o	r respiratory arres	rid 21001 st,	Approximate Interval Between Onset and Death
	/Medical Examiner	er	resulting in death)  Sequentially list conditions, if any, leading to immediate	. Athe	consequence of):  ADSCAPE  Consequence of):	1915					ipens
8760,	se be sicia e bur	lical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a c	consequence of):						
O. Box 6	that the death certifical ed by the attending phy detached for use as th	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at tin 9 ☐ Unknown	Fetal death	3 □Ectopic pre 5 □ Other (spe				23d. Date of d Month	elivery Day Year
rds, P.	quires that in signed by uld be deta	ed by Ph	Part II. Other significant conditions of	ontributing to death but	not resulting in the	e underlying ca	use given	in Part I.		acco use contribute	to the cause of death?  Probably 4 Unknown
al Reco	: The law requir cate has been si page 2 should	Complete	. ),						24a. Was an autopsy perform	ed? prior to death?	autopsy findings available completion of cause of s 2 \( \text{No} \)
Division of Vital Records, P.O. Box 68	hysician this certifi al director	To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death Natural 5 Pending investigation	Hospital: 1 ☐ Inpatient  28a. Date of Injury (Month, Day Y		of 28	Other: c. Injury a Work?	-		ce 6 Other (Sp	ecify)
Divis	To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not be determined		r - At home, farm, (Specify)	street, factory,	office	2	28f. Location (Stre City or Town,	eet and Number or I State)	Rural Route Number,
	he Hospi in 24 hour he Funer pletely fill	Medical	29a. Certifier (Check only one)  Certifying Ph	nysician: To the best of ininer: On the basis of example and manner state	xamination and/or	eath occurred a investigation, i	t the time, in my opin	date and place, a ion, death occurre	and due to the cau ed at the time, dat	use(s) and manner are and place, and du	as stated. ue to the cause(s)
	To t withi To t	Σ	29b. Signature and title of certifier	Million	77	29c.	License r	2595)		d. Date signed (Mon	
	(3)		30. Name and address of person who MICHAEL D. CROWL.		th (Item 23a) (Typ	-	E EAS	TON, MD	21601		
	Stat Registra		31. Date filed (Month, Day, Yexpp	1 8 2005 gistrar's	s Sqnature	Nº A		gi.			

		1 - For Stete Registrar			Certifica		ealth and M Death		leg. No. 0	35	16019
Physicia	en	1. Decedent's Name (First, Middle, I	•					2. Date of Dea Month	th Day	Year	3. Time of Death
/Medic	al	SHIRLEE HARRIN						April	25 2	2005	12:05 PM
Examine	er	4a. Facility Name (If not institution, g Genesis Health			1		Location of Death	_	4c. Count	ty of Death	
Funeral			Sex 7. Ag	ne PIN		Ea: ler 1 Year	ston If Under 24 Hrs.	8. Date of Birth	1	Talb	
Director		218-16-7932	1□ M 2 🔏 F	79	Yrs. Month	s Days	Hours Min.	8. Date of Birth (Month, Day JUNE 8	1925	MARY	lace (State or Foreign try) LAND
*		Usual Residence of Decedent  10a. State 10b. County		10c. City, Tow	m or l continu					1	
of sho	ŏ	MD TALBO	т		STON						0d. Inside City Limits 1√2 Yes 2 □ No
7 28e	Funeral Director	10e. Street and Number		Li		Zip Code			0g. Citizen of	What Cour	**
23e o	ai D	610 DUTCHMANS	LANE			21	601			US	•
ems er m	iner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. Was Dec	edent of His	spanic Origin? (Spe n, Mexican, Puerto I	cify Yes or No-		ce - Americ	an Indian,
P. E	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 📉			2 <b>X</b> ) No	Specify:		Speci		ITE
atural Ed E	edt	15. Decedent's	Year or Dates:	16a	. Decedent's Us	sual Occupa	tion		16b. Kind of E		
Median "n	plet	(Specify only highest g Elementary/Secondary (0-12)	rade completed) College (1-4ort		(Give kind of v life. DO NOT	vork done d use retired)	uring most of worki	ng		300110001111	2001.9
t, tre	Completed	12	2		NURSING	SUPER	VISOR		HOS	PITAL	
even even	Be	17. Father's Name (First, Middle, Last	st)				18. Mother's Name		Maiden Suma	me)	
d Mer narke	ို	LAWRENCE SMITH  19a. Informant's Name/Relationship	(Time Brint)	101	Mailler Addre	(011		RELAND			
Ith an	1	BRUCE HARRINGTON		1			nd Number or Rura L ROAD, (		•		Code)
item item othe		20a. Method of Disposition		20b. Pface o	of Disposition (Nature), crematory or	ame of	D		20c. Location		wn, State
int: If		¥☐ Burial 2 ☐ Cremation 3  3 4 ☐ Donation 5 ☐ Other (Spec	Removal from State		CLY CEME		4-29-	2005	RIDGE	т.у. м	ARYLAND
Department of Health and Mental Hygjene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, it a Medical Exarctment must be notified at once.	Ì	21. Signature of Funeral Service Lic	ensee		22. Name a	and Address					
5 5 3		JOHN R. M			200 S	- HAR	RISON ST	EASTON.	MD 21	601	HOME PA
		23a. Part1. Enter the disease, or co shock, or heart failure. List on									Approximate Interval Between Onset and Death
ysician //edical	ĺ	Immediate Cause (Final disease or condition resulting in death)	a. Kespi	ratory	fail	re					
aminer		- 1	Due to (or as	a consequence	of):	incal.	effusion met	n.			
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Indentying Cause (Disease or injury that initiated events	b. Due to (or as	a onsequence	of):	rai	CHOSE				
sician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	· Brea	st ca	nar	Wit	in met	istas	is		
ysician and burial	cai E	1000/king in ocalin) East	Due to (or as	a consequence	of):						
ž e .			d								
attending pl	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome						23d. Da	ate of delive	ry
ed for	sicia	in the past 12 months? 1 ☐ Yes 2 No	1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death time of death	3 DEctopic 5 Other (s						Day Year
etached	Phys	9 Unknown 1						1		12.1	
engi p eq	ò	Part II. Other significant conditions	_								e cause of death?
should be	eted	hydronephra							s 2 No		ably 4 Unknown
has Je 2	Completed	sicinally to	metas	anc ,	oreast	t Cer	ner	24a. Was a autops	v	Were autop prior to con death?	sy findings available apletion of cause of
pa		25. Was case referred to medical					00 Diagram	1 ☐ Yes 2	No No	1 🗆 Yes	2 🗆 No
o iii		examiner?	Hospital:	ınt 2□ER/Ou	ıtpatient 3□ □	Other	26. Place of Death  4 X Nursing Hom	111111111111111111111111111111111111111		ner (Specify	1
director, pag	o Be		28a. Date of Inju	ry 28b.	Time of njury	28c. Injury Work	at 2	8d. Describe ho			
this certifi	0	27. Manner of Death			,		es 2 No				
this certifi	0	1 Natural 5 Pending 2 Accident investigation	on							har or Dural	Route Number
this certifi	0	1 Natural 5 ☐ Pending	be as Blood (In)	ury - At home, fa	rm, street, facto		2	Bf. Location (St. City or Town	eet and Numl , State)	on or murar	riodio regilibor,
this certifi	Certification; To	1 Natural 5 Pending 2 Accident investigati 3 Suicide 6 Could not determine	be 28e. Place of Injubulding, etc	c. (Specify)		ry, office		City or Town	, State)		
this certifi	Certification; To	1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier  1 Certifying F	be 28e. Place of Inju	c. (Specify) of my knowledge examination an	a. death occurre	ry, office	a, date and place, a	City or Town	, State)	anner as sta	hate
this certifi	0	1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)  29b. Signature and title of certifier	28e. Place of Injubuilding, etc.  Physician: To the best of and manner sta	c. (Specify) of my knowledge examination an	e, death occurred d/or investigatio	d at the time in, in my opi	a, date and place, a nion, death occurre	City or Town	use(s) and mate and place,	anner as sta and due to	ated. the cause(s)  Oay, Year)
this certifi	Certification; To	1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)  1 Pending investigati 6 Could not determine	28e. Place of Injubuilding, etc.  Physician: To the best of and manner sta	c. (Specify) of my knowledge examination an	e, death occurred d/or investigatio	d at the time	a, date and place, a nion, death occurre	City or Town	use(s) and mate and place,	anner as sta and due to	ited. the cause(s)
rate location.  Red in by the funeral director.	Certification; To	1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)  29b. Signature and title of certifier	28e. Place of Injubuilding, etc.  thysician: To the best of and manner sta	c. (Specify)  of my knowledge examination an ted.	e, death occurred d/or investigation	d at the time in, in my opi	a, date and place, a nion, death occurre	City or Town	use(s) and mate and place,	anner as sta and due to d (Month, D	ated. the cause(s)  Oay, Year)

5mothlemes

		For State Registrar	State	of Marylan		artment <i>rtificate</i>			and M		giene Reg. No.	005	160	)20
Physicia	an	1. Decedent's Name (First, Middle, L		0	. 4.1					2. Date of De	Day	Year	3. Time o	of Death
/Medic		James			、计长					APRIL				M
Examin	er	4a. Facility Name (If not institution, gr	. 1			1	fown, or	Location o	of Death			County of Dea		
		5. Social Security Number 6.	<u> НОЅР</u> <sub>Sex</sub>	7. Age (In yrs.	last hirthday)	If Under 1		If Under:	24 Hrs.	8 Date of Bir		ALBOT		or Foreign
Funeral Director		217-03-3567	1 <b>X</b> M 2□F	90	Yrs.		Days	Hours	Min.	8. Date of Bir (Month, Da	$y, Y \theta a r$	.915 Ma	thplace (State ountry)	or r oreign
D		Usual Residence of Decedent								, mprii	20,1	717 110		
rylan show		10a. State 10b. County		10c. City	y, Town or Lo	ocation							10d. Inside (	
e Ma Sa-f s	Director	Delaware New Cas	tle	Wi	lmingt								Yes	s 2 No
death with the Maryland	Dire	10e. Street and Number				10f. Zip (	Code				10g. Citiz	en of What C	ountry?	
s 23e	Funeral	1800 Broom Stree	t 10 Was Day	edent Ever in U.	6 12		1980		-:-2 /C-	ifVN-	USA	4. Race - Ame	arioon logica	
ter de Itam	Ľ.	<ul><li>11. Marital Status</li><li>1 ☐ Never Married 2 ☐ Married</li></ul>	Armed F	orces?	.5. 13.	If Yes, speci	fy Cuba	n, Mexican	gan? (Spo , Puerto	ecify Yes or No Rican, etc.)	)-	Black, Whi		
urs at	þ	3 Widowed 4 □ Divorced	If Yes, G Year or	2 No ive Dates:		1 ☐ Yes 2	No	Specify:				Specify:	Black	
within 72 hours atter ene. than *natural', or Its ite Mudical Examina	Completed	15. Decedent's l (Specify only highest g	ducation	)	16a. Dece	dent's Usual	Occupa	ation	t of work	ina	16b. Kin	d of Business		
thin in it	npie	Elementary/Secondary (0-12)		(1-4or 5+)	life.	kind of work DO NOT use	e retired,	)	O WOIK	iiig				
tiled w Hygier Sthar th	S	10			Coo	k		40.14.4		(ett	Hote			
be ti	Be	17. Father's Name (First, Middle, Las								e (First, Middle,		Sumame)		
should I	ဥ	Garfield  19a. Informant's Name/Relationship	Smit	n	19h Mailie	na Address	(Street a	Man		Collin:		Tour State	Zin Code)	
and 2 s saith an n 27 is i		Faith Brown / N								ceston,				
Heal Heal tam	1 1	20a. Method of Disposition	11000	20b. P	lace of Dispo					Date		ation - City or		
Pages nent of int: If it iry or o		1 Burial 2 Cremation 3		JIGIO	emetery, crei wtown				14-25	5-2005	Cord	lova. Ma	ryland	
permit. Pages 1 and 2 should be tiled within 72 hours after death with the Marylan Department of Heatilt and Mental Hygiene. Important: If item 27 is marked othar than *natural*, or Itams 23e or 28a-1 show eny injury or other traumatic event, I'lly Martical Examination to the traumatic event, I'lly Martical Examination to the traumatic event.	T	21. Signature of Funeral Service Lice		- 110						eral Ho		10 va , 11a	.ry rana	
Deg Period						426 I	le S Dove	mitn r Str	rune eet,	erai noi , Eastoi	me n,Mar	yland	21601	
		23a. Part1. Enter the disease, or con shock or heart failure. List on	nplications that one cause on	caused the death	n. Do not ent	er the mode	of dying	g, such as	cardiac o	or respiratory a	rrest,		Approxima Interval Be	ite itween
Physician		Immediate Cause (Final disease or condition	a	110	ani +	400	7						Onset and	Death
/Medical Examiner		resulting in death)	Due to	(or as a conseq	ence of):		3							10
	_	Sequentially list conditions,	b. Due to	(or as a consequ	Uppos of)	Sha	-5	1-	/			7	nmy	ps
nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	M.	1/1/01	e IM	1 12			40.1	9-3 6				
exection and ial-tra	Exa	that initiated events resulting in death) Last	Due to	(or as a consequ	uence of):	4 34/6			an	1-1-				
			d				_							
entitica ing pt	Physician/Medical	IF FEMALE:												
ath ce ttend or use	an/l	23b. Was decedent pregnant in the past 12 months?	1 🗀 Live	atcome of pregna birth 2 □ Fetal	Ideath 3□	Ectopic pre					2:	3d. Date of de Month		Year
aw requires that the death certiti as been signed by the attending 2 should be detached tor use as	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Preg 9⊟Unki	nant at time of de nown	eath 5	Other (spe	cify)						,	
that the ed by detac	P.	Part II. Other significant conditions	contributing to	death but not rest	ulting in the u	nderlying ca	use give	en in Part I.		23e. Did to	obacco us	e contribute to	the cause of	death?
uires n sign	d by	COF	0		,		,	-4		10	Yes 2□	]No 3 □ Pi	robably 4 📮	Mknown
s beer	iete	chami-	AM	1 - 21	2-	19/12	Jak		,	24a. Was		24b. Were at	utopsy findings	available
The lay te has age 2	Completed				0	///	4_20	neg		autop perfo 1 ☐ Yes	osy rmed?	prior to death? 1 ☐ Yes	completion of o	cause of
ian: rtifica stor, p	BeC	25. Was case referred to medical						26. Place	of Death	(Check only o		113.00		
hysic his ce I direc	To I	examiner? 1  Yes 2 No	Hospital:	Inpatient 2	ER/Outpatier	ıt 3□ DOA	Othe	<sup>0</sup> . 4 □ Nu	rsing Ho	me 5□Resid	dence 6	□Other (Spe	cify)	
ing P	on:	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date (Mo	of Injury nth, Day Year)	28b. Time of Injury		c. Injury Work			28d. Describe f	now injury	occurred		
tand Jeath tor: /	cat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not	he -			M		/es 2 □ l		OOL Leasting #	^44	A/		
or A after Direc	Certification:	4  Homicide determine	build	e of Injury - At ho ling, etc. <i>(Specif</i> y	me, rarm, str /)	eet, factory,	опісе		1	28f. Location (S City or Tov		Number or A	urai Houle Nun	nber,
spitel lours naral filled		29a. Certifier 18 Certifying F	hysician: To th	e best of my kno	wledge, deatl	n occurred a	t the tim	e. date and	d place.	and due to the	cause(s) a	and manner as	stated.	
To the Hospitel or Attanding Physician: The I within 24 hours after death. To tha Funaral Director: Atter this certificate ha completely filled in by the funeral director, page	Medicai	(Check only 2 Medical Exa	miner: On the	basis of examinat nner stated.	tion and/or in	vestigation, i	in my op	pinion, deat	th occurr	ed at the time,	date and p	place, and due	to the cause(	s)
To th withir To th	M	29b. Signature and title of certifier	- A	) //	, )	29c.	License	number			29d. Date	signed (Mont	h. Day, Year)	
		H13/31	) IL	1 ME	1	1	12	57	50	'	41	126/	05	
		30. Name and address of person who	•	ise of death (Item	23a) (Type,	Print)						t		
		Robert Sanchez,		508 Id1		Ave.,	Eas	ston,	Mary	1and 21	601			
Stat Registra		31. Date Ap Konth, Pay Year	32.	Registrar's Signa	May X	E								

				ate of Maryland	d / Depa	artmen	t of H	ealth a		-		2 n n i	TT THE STATE OF TH	10001
	_		State     Ragistrar  1. Decedent's Name (First, Middle, Last)		Cer	tificate	e or L	Jeatn	10	. Date of De	Rag. No		)	10021
Н	Physici	an								Month	Da	1	AΓ	3. Time of Death
	/Medic Examir		Peggy Jean Snyd  4a. Facility Name (If not institution, give street			4b. City.	Town, or	Location of		May	40	County of D		5:15 PM
1	LAGIIII	lei				-						ashin		n
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la	ast birthday)			Stone V		Date of Birl	th			e (State or Foreign
	Director		218-52-4904 1 M 2 Usual Residence of Decedent	DXF 5.	6 Yrs.	Months	Days	Hours	Min. F	reb 1				yland
	how		10a. State 10b. County	10c. City	, Town or Lo	cation							10d.	Inside City Limits
	8a-1 s	cto	Maryland Washing	con 1	Hager	stow	n							Y Yes 2 □ No
	eth with the Marylan s 23e or 28a-f show wst be nutitled at	Director	10e. Street and Number			10f. Zip		1740				izen of What ited		
	a 23e	Funeral	161 Summit Ave Ap		2 10 1				1.0 (0)					
	ter dee	Š	An	as Decedent Ever in U.S med Forces? ]Yes_2 [XNo	5. 13. V	Yes, spec	ify Cubar	n, Mexican,	, Puerto Ric	y Yes or No can, etc.)		14. Race - A Black, W		
936	urs al	þ	If '	res, Give ar or Dates:	1	☐ Yes 2	2 <b>X</b> ) No	Specify:				Specify:	Whi	te
21215-0036	n 72 hours after deeth with the Maryland "natural", or Itema 23e or 28a-1 show Alcal Exertiment assi be nutilised at	Completed	15. Decedent's Education (Specify only highest grade com	aleted)	16a. Deced	lent's Usua	l Occupa	tion	of working		16b. K	ind of Busine	ss/Indus	try
2	c * 3	nple		llege (1-4or 5+)					of working		_			
2			12		но	rse	·····		inte			estri	an	Equip.
anc	od a b	Be	17. Father's Name (First, Middle, Last)  Jack Llewellyn							First, Middle, aR.				
Maryland	d 2 should b th and Menta 7 is marked treumetic e	은	19a. Informant's Name/Relationship (Type, Pr	int)	19b Mailin	a Address	(Street a					r Town, State	Zin Co	de)
<u>8</u>	7 1 tre		Shannon D. Clay(d											21740
ē,	~ x a ⇒		20a. Method of Disposition	20b. Pl	ace of Dispos metery, crem				Date		_	cation - City		
Ë			1 ☐ Burial 2 【XCremation 3 ☐ Remove 1 ☐ Donation 5 ☐ Other (Specify)		ithsb				5/3/0	0.5	Smi	thsbu	ra	Maryland
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee	. 0 0										neral Ho
<u> </u>	8258		1 L Caniel C	Tauley	13	31 E	aste	ern I	Blvd.	N Ha	ger	stown	MD	21742
			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cau	s that caused the death, se on each line.	. Do not ente	er the mode	e of dying	, such as c	cardiac or re	espiratory ar	rest,		Int	proximate erval Between
	Pnysician	G.	Immediate Cause (Final disease or condition	Lu	1	Cor							or ਜ	mon h
	/Medical Examiner		resulting in death)	Due to (or as a consequ										
		_	Sequentially list conditions, b.	Due to (or as a consequ	ence of):								-	
	uted	Examine	cause. Enter Underlying											
Ć,	sician and buriat-transit	Exa	triat trittated avents	Due to (or as a consequ	ence of):									
8760,	death certificate be executed e attending physician and d for use as the burral-transit	cal	d											
9	ndiffica ng ph a as th	ed	IF FEMALE:										1	
Вох	eath certific attending p	lan/	23b. Was decedent pregnant in the past 12 months?	es, outcome of pregnar Live birth 2 Fetal	death 3 🗌	Ectopic pre	egnancy				2	23d. Date of o	lelivery Da	v Year
		Physician/M	1 Ves 2 No	]Pregnant at time of de ]Unknown	ath 5□	Other (spe	ecify)					WOTH	Da	y real
P.0	that the ed by detac		Part II. Other significant conditions contributi	ng to death but not resul	Iting in the un	iderlyina ca	use give	n in Part I.		23e. Did to	bacco u	se contribute	to the c	ause of death?
Records,	law requires that the as been signed by th 2 should be detache	d by				, ,					/			4 □Unknown
8	aw requir is been si 2 should	Completed								24a. Was	an	24b. Were	autopsv	findings available
Re	0 2 0	mo							_	autop perfor 1 ☐ Yes	med?	prior to death	?	ation of cause of
		Bec	25. Was case referred to medical					26. Place	of Death (C	Check only o		1011	95 2	-
of <	dis ye	10	examiner? 1 ☐ Yes 2 ☐ No Hospita	1 Inpatient 2 E	R/Outpatient	3 □ DO	A Other	. 4 🗆 Nurs	sing Home	5 esid	ence 6	S □Other (Sp	pecify)	
	ing Ph víter th uneral		27. Manner of Death 28a 1 ☑Natural 5 ☑ Pending	Date of Injury (Month, Day Year)	28b. Time of Injury	28	3c. Injury Work?	at ?	28d	I. Describe h				
Sio	Attending in death. sector: After by the funer	cat	2 Accident investigation			М		es 2□N						
Division	or At after c Direc in by	Certification:	4 Homicide determined 28e	. Place of Injury - At hor building, etc. (Specify)	ne, farm, stre	et, factory,	, office		281.	City or Tow		d Number or i	Rurai Ro	ute Number,
_	Hospitel		29a. Certifier 1 Cartifying Physician:	To the best of my know	vledge death	occurred a	at the time	date and	nlace and	due to the o		and manner	ac state	
	To the Hospitel or Attending I within 24 hours after death.  To the Funerel Director: After completely filled in by the funer	Medical	2   Madical Examinar: O	n the basis of examination the basis of examination displayed.	on and/or inv	estigation,	in my opi	nion, death	occurred a	at the time, o	date and	place, and d	ue to the	cause(s)
	To the within 2.  To the I complete	Σ	29b. Signature and title of certifier	0.		29c.	License	number		2	29d. Date	e signed (Mo	nth, Day	Year)
•			Muchael 1.	Milan	MI	7	0	416	6)			5 . 2	.05	
4	1-4		30. Name and address of person who complete Michael MCCo (31. Date filed (Month, Pay, Year)	d cause of death (Item	23a) (Type, F	Print)	1.	1 /	/10 3		1 -		٥	1. 0
	Sta	te	31. Date filed (Month, Pay, Year)	32. Registrar's Signatu	1110	1100	67116	1 (	anpo	9 117	c 5)	7000	<u></u>	INO.
	Registr	ar	MAY U 3 2005	Meren ,	A. A.	rete								

			1 - For State Registrar	C	epartment of Health and N Certificate of Death	Reg.	No.2005 16022
	Physici /Medio Examir	cal	Decedent's Name (First, Middle, Last)     Paul Eugene Schm     Aa. Facility Name (If not institution, give	idt, Sr.	4b. City, Town, or Location of Death	2. Date of Death Month May	Day Year 1 2005 6:00 PM M  4c. County of Death
	Funeral	161	1202 Rabbit Court 5. Social Security Number 6. Secu	7. Age (In yrs. last birtho	Hagerstown  Hagerstown  Hagerstown  Hagerstown  Hagerstown	8. Date of Birth	Washington County
	Director		218-30-8617 Usual Residence of Decedent	] M 2□ F 70 Yrs		Jan 27 1	1935 Maryland
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Exemple Trust be nullised at ance.	To Be Completed by Funeral Director	10a. State   10b. County	Inited States  Inited States  Is Race - American Indian, Black, White, etc.  Specify: White  Chick Mfg.  Iden Sumame)  Icy  Ity or Town, State, Zip Code)  Iaryland 21740  Chocation - City or Town, State  Ingerstown Maryland  Ciery Funeral Home			
8760,	Physician and // Medical Examiner tune points in the private tune in the private	dical Examiner	23a. Part 1. Enter the disease, or compliance, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	Du to (or as a consequence of):			
O. Box 68	death certifi e attending p od for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery  Month Day Year
rds, P.	es tha	by	Part II. Other significant conditions con	stributing to death but not resulting in th	e underlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death?
Hecord	The law ate has b page 2 sl	Completed				24a. Was an autopsy performed	
VITal	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:		h (Check only one)	
0	ng Phys fter this ineral dii	tion: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)  28b. Tim- Injury	e of 28c. Injury at	me 5 Residence 28d. Describe how in	e 6 ⊡Other (Specify) njury occurred
DIVISION	P dite	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Street City or Town, St	t and Number or Rural Route Number, tate)
	To tha Hospital within 24 hours a To tha Funaral to completely filled	edical	29a. Certifier 1 ☐ Certifying Phys (Check only one) 2 ☐ Medical Examir	sician: To the best of my knowledge, di ner: On the basis of examination and/o and manner stated.	eath occurred at the time, date and place, r investigation, in my opinion, death occurr	and due to the cause red at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
	To tha P within 24 To tha F complete	N.	29b. Signature and title of certifier	1 hr	29c. License number  127673	29d.	Date signed (Month, Day, Year)  Cy  SVO  TO STORY  Date signed (Month, Day, Year)
5t	1441		30 time of address of person who co	mpleted cause of death (It in 2011) (Type	PR, Print)	enque!	Rel Hegerstown
	Sta Registr	- 1	31. Date filed (Month, Day, Year)	32. Registrar's Signature	A. c. de s		WN 21742

4	State of Mary	land / Department of Health a Certificate of Death	nd Mental Hygiene	1602			
Physician /Medical	1. Decedent's Name (First, Middle, Last) William Gilbert SCHENSKY		2. Dete of Deeth Month Dey Year May 1, 2005	3. Time of Death 9:30 p.m.			
Examiner	4a Fecility Neme (If not institution, give street end number)  Julia Manor		m, or Location of Death 4c. County of Death erstown Washingto				
Funeral Director	5. Social Security Number 6. Sex 7. Age (In 220-30-9857 12 M 2□ F 77	n yrs. last birthday) If Under 1 Year If Under 2 Yrs. Months Days Hours	4 Hrs. 8. Date of Birth Min. (Month, Day, Year) 9. Birthp	olace (State or Foreign ntry) 1and			
Marylend f show	Usuel Residence of Decedent  10a. State 10b. County 10  Maryland Washington 10	c. City, Town or Location  Hagerstown	1	0d. Inside City Limits			
h with the 13s or 28s at be notifi	10e. Street end Number 11 W. Baltimore Street	10f. Zip Code 21740	10g. Citizen of What Cour Washington	-			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylend Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: if item 27 is marked other than *natural', or items 23a or 28e-f show important: if item 27 is marked other than *natural be indiffied at once.  To Be Completed by Funeral Director	11. Marital Status  1 ☑ Never Married  2 ☐ Married  1 ☐ Yes 2 ☑ No  If Yes, Give  Year or Dates:	r in U,S. 13. Was Decedent of Hispenic Orig If Yes, specify Cuben, Mexican, 1 ☐ Yes 2₺ No Specify:					
within 72 ho ene. than 'natura he Medical I	15. Decedent's Education (Specify only highest grede completed)  Elementary/Secondary (0-12) College (1-4or 5+)	16e. Decedent's Usual Occupation (Give kind of work done during most life. DO NOT use retired)  minister	of working 16b. Kind of Business/Inc	dustry			
would be filed Mental Hygie arked other artic event, II	17. Father's Name (First, Middle, Last) Gilbert Schensky	18. Mother	or's Name (First, Middle, Maiden Sumame)  1a Virginia Willingham				
2 should in and Men is marker raumatic	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number	or Rurel Route Number, City or Town, State, Zip	-			
permit. Pages 1 and 2 Department of Health, Important: if Item 27 is any injury or other tra pnce.	I L Buriai 2 Micremation 3 Linemoval nom State	21/ ROCK Willow Av  Ob. Place of Disposition (Name of cemetery, crematory or other place)  Hagerstown Crematory	Date 20c. Location - City or To	wn, State			
permit. F Departme Importan any injur phee.	21. Signature of Funeral-Service Licensee	22. Name and Address of Facility		<u> </u>			
W 255	23a. Part1. Enter the disease, or complication, that caused the shock, or heart failure. List only one cause on each line.	me -		Approximate Interval Between			
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	Contro interfice (or to (or as a consequence ol):	and the same	Onset and Death			
normicate be executed anding physician and use as the burial-transit in/Medical Examiner	if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury c	to (or as a consequence of): to (or as a consequence ol):					
at the deeth certing by the attending etached for use e	Part II. Other significant conditions contributing to death but no	ot resulting in the underlying cause given in Part I.	23b. Did tobecco use contribute to				
uras that t signed by Id be deta d by Ph	Concience Protest Conce	Long blichden	1 ☐ Yes 2 ☐ No 3 ☐ Prot  24a. Wes an autopsy 24b. We	ably 4 ∰0nknow are autopsy findings			
Ine law raquiras that the deeth cert as been signed by the attending page 2 should be detached for use.  Completed by Physician/M			performed? ave	ailable prior to mpletion of cause death?			
	25. Was case referred to medical examiner?		of Death (Check only one)	Yes 2 No			
hys His T	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient  27. Manner of Deeth 1 ☐ Natural 5 ☐ Pending (Month, Day Yes	28b. Time of 28c. Injury at	ing Home 5 Residence 6 Other (Specif) 28d. Describe how injury occurred	<i>'</i> )			
tal or Attanding P rs eftar death. al Director: Aftar t led in by tha funar: Certification;	2 Could not be	At home, farm, street, factory, office	28f. Location (Street and Number or Rura City or Town, Stete)	l Route Number,			
Hospi 24 hou Funer Funer Stely fill	29a. Certifier (Check only one)  1 ☐ Certifying Physician: To the best of my one)  1 ☐ Certifying Physician: To the best of my one and manner stated.	knowledge, death occurred at the time, date and mination and/or investigation, in my opinion, death	place, and due to the cause(s) and manner as st occurred at the time, date and place, and due to	ated. the cause(s)			
To the comple	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, I	• •			
4-4	30. Name end address of person who completed cause of deeth VASAV 7 DATTAMO 34	(Item 23e) (Type, Print)	570WN MD 21740				
State Registrar	31. Dete filed (Month, Day, Year) 32. Registrer's 5	Signature					

DHMH 16 Rev 6/95

			For Stete Registrer	State of M	/larylar		artment of F		d Mental Hy	/giene		1.0001		
			Decedent's Name (First, Middle,	Last)					2. Date of D	eath	<del>. U U U</del>	3. Time of Death		
	Physici /Medio		Carol Seaquist						Month April	2 O	Year 2005	1820 M		
	Examir		4a. Facility Name (If not institution,	give street and numbe	or)		4b. City, Town, o	r Location of Do	-		County of Death	1 1020		
			Anne Arundel Me	dical Cent	er		Annapo!	lis		Anı	ne Arund	e1		
	Funeral		Social Security Number		Age (In yrs.	last birthday)	If Under 1 Year Months Days		Irs. 8. Date of B	irth		lace (State or Foreign		
	Director	2	230-46-3860	1 □ M 2 🖫 F	69	Yrs.			Dec. 27, 1935 Virginia					
	and *		Usual Residence of Decedent  10a. State 10b. County		10c. C	ty, Town or Lo	ecation					0d. Inside City Limits		
	Aaryli sho	5					10000011					1 ∑XYes 2 □ No		
	28a-	Director	Maryland Anne A	rundel	Ann	apolis	10f. Zip Code	-		10a Citis	zen of What Cour			
	with		140 Spa View Av	enue			· ·					,		
	ms 23	era	11. Marital Status	12. Was Deceder		J.S. 13. 1	21401 Was Decedent of H	ispanic Origin?	(Specify Yes or N	Unite	ed State			
က	r Iter	Funeral	1 Never Married 2 Married	Armed Force				an, Mexican, Pu	(Specify Yes or Nuerto Rican, etc.)		Black, White,	etc.		
Maryland 21215-0036	within 72 hours atter death with the Maryland ene. then "naturel", or Items 23a or 28a-f show fra Madical Examinar must be colified at	b	3 Widowed 4 Divorced	If Yes, Give Year or Dates			1□ Yes 2□ No	Specify:			Specify: whi	te		
2	72 ho	Completed	15. Decedent's (Specify only highest				dent's Usual Occup		working	16b. Kir	nd of Business/Inc	dustry		
7	ithin	nple	Elementary/Secondary (0-12)	College (1-4o	r 5+)	life.	DO NOT use retired	d)	HOIKING					
'n	ygier ygier yer th			4		edi	tor				cation			
and	ould be filed v Mental Hygie varked other t natic event, In	Be	17. Father's Name (First, Middle, La	ist)				18. Mother's I	Name (First, Middle	e, Maiden :	Sumame)			
3	should ind Men s marke umatic	<sup>1</sup>	Horace Bluford						ola Princ					
a	12 sho h and 7 is m treum	90 5	19a. Informant's Name/Relationship Edgar Seaquist/						Rural Route Numb			Code)		
	uges 1 and 2 should be filed within 72 hours atter death with the Marylar It of Health and Mental Hygiene. If item 27 Is marked other then "naturel", or items 23a or 28a-f show or other treumatic event, It a Mudical Examinar munt for cultiliar at		20a. Method of Disposition	nusbanu	20b 1				nnapolis,			Ctata		
٥	Pages nent of int: If its iry or o		1 □ Burial 2 🖳 Cremation 3		.6		sition (Name of natory or other place	1		200. L00	cation - City or To	wn, State		
altimore,	permit. Pages 1 and Department of Health Importent: If item 27 any injury or other to once.		<ul><li>4 □ Donation 5 □ Other (Spe</li><li>21. Signature of Funeral Service Lice</li></ul>		Ba	ltimore	e Cremato	ry  4-2	22-05	Balt	imore, l	10		
Ba	permit, Page Department of Importent: If any injury or once.		4 8 - ++-	Dom al	u	1,	7 Dute a	£ Cl	John M. T	aylor	Funeral	Home, In		
			23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that caus	ed the dea				cester St		lapolis,	MD 21401 Approximate		
	Dharistan		shock, or heart failure. List or Immediate Cause (Final	N								Interval Between Onset and Death		
	Physician /Medical		disease or condition resulting in death)	a. Due to (or a	+1 5	US Law	- Organ	- taul	رسف					
	Examiner			. 5		She								
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (u. a										
	cuted nd ransii	Examiner	that initiated events	c										
Ö,	e exe ian a urial-(		resulting in death) Last	Due to (or a	is a consec	quence of):								
8760	icate be executed physician and s the buriat-transit	dicai		d										
9	ertific ling p e as	Φ :	IF FEMALE:											
ROX	death certifi e attending p id tor use as	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1 ☐ Live birth	2 Feta	al death 3	Ectopic pregnancy			2	3d. Date of delive Month	ry Day Year		
	0 0	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant 9□ Unknown	at time of o	leath 5	Other (specify)				World	Day Tour		
J.	g g g	Ph	Part II. Other significent conditions	s contributing to death	but not res	ulting in the ur	nderlying cause give	en in Part I	23e. Did	tobacco us	se contribute to th	e cause of death?		
ecords,	uires signe	d by	Ilens	•			,			Yes 2		ably 4 \( Unknown		
Ö	w requ	ete		<del></del>					24a. Was		0.4h 14/	e e e e e e e e e e e e e e e e e e e		
Ĕ	The fav	Completed							<ul> <li>auto</li> </ul>		prior to con death?	sy findings available apletion of cause of		
-	(0 17	e C	25. Was case referred medical					50 DI (6	1 ☐ Yes	2 1 No	1 🗆 Yes	2 🗆 No		
>	ysicie is cert direct	o B	examiner?	Hospital:	tiont 2	ER/Outpatien	t 3 DQA Othe	300	Death <i>Check onl</i> J Home 5 - Resi		Cothes (Coo-if			
Ö	g Physer this eral di	n: T	27. Mann Death	28a. Date of In	jury	28b. Time of	28c. Injury	at	28d. Describe			)		
0	Attending Physicien: r death. ector: After this certific by the funeral director.	atlo	1 ✓ atural 5 ☐ Pending investigat	(Month, E	ay rear)	Injury	Worl M 1 □ `	r? Yes 2 □ No						
UIVISION		Certification:	3 Suicide 6 Could not	ed 286. Place of I	njury - At h etc. <i>(Specii</i>		eet, factory, office		28f. Location ( City or To		Number or Rural	Route Number,		
5	Ital or rs afte ret Dire	Cer												
	e Hospital or 24 hours atte e Funeret Dii letely filled in	edical	29a. Certifier 1 ☐ Certifying (Check only one) 2 ☐ Medicel Ex	Physicien: To the bes aminer: On the basis and manners	of examina	owledge, death ation and/or inv	occurred at the time restigation, in my or	ne, date and pla pinion, death o	ace, and due to the courred at the time,	cause(s) a date and p	and manner as sta place, and due to	ated. the cause(s)		
	To the lawithin 2. To the lacomplet	Med	29b. Signature and title of certifier	and manners	naidu.		29c. License	number		29d. Date	signed (Month, L	Day, Year)		
	C > F 0		XICA	$\rightarrow$		_>	Dock	35820	37	41	20/05			
		ŀ	30. Name and address of person wh	o completed cause of	death (Iter	n 23a) (Type	Print)		- 1	- '	- (- )			
			1-1-11-11	ing MO	A	ne Arn	ndel Me	Jalo	ante, An	napel	SMD Z	1401		
	Sta	-,4	31. Date filed (Month, Day, Year)	32 Regis	trar's Signa							•		
	Registr	ar	ADD 25 5	אחחים		b A	. 10							

			1- For State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.	11115 16025
	Physici		1. Decedent's Name (First, Middle, Last)  2. Date of Death  Month APRIL 19	3. Time of Death , 2005 2:28P. M
	/Medic Examir	cal ner	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. C	County of Death E ARUNDEL
	Funeral Director		5. Social Security Number  6. Sex  1  Age (In yrs. last birthday)  1  Age (In yrs. last birthday)  Yrs.  1  Age (In yrs. last birthday)	9. Birthplace (State or Foreign Country) Maryland
	72 hours after death with the Maryland natural', or Items 23a or 28a-1 show dical Examinar must be rodified at	Il Director		10d. Inside City Limits 1 ☐ Yes 2 ☐ No en of What Country?
Maryland 21215-0036	d within 72 hours after death with the Marylan liene. r than "natural", or Items 23a or 28a-f show the Modical Examiner mest be notified at	ted by Funeral	3 Widowed 4 Moivorced If Yes, Give 1 Year or Dates: 1068-1070	d States  4. Race - American Indian, Black, White, etc.  Specify: white  d of Business/Industry
1218	within ene. than "	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  Elementary/Secondary (0-12)  College (1-4or 5+)  telephone installer  pho	ne company
land 2	be filed Ital Hyg Id othe avant,	To Be Co	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden S.	
<b>lary</b>	2 should and Men Is marks	-	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or 1	Town, State, Zip Code)
Baltimore, N	Pages 1 and 2 should nent of Health and Mer ant: If itam 27 Is marke ury or othar traumatic		Lucile Stokes / mother 1138 Bay Ridge Rd. Annapolis, MD  20a. Method of Disposition  **X2Burial 2 Cremation 3 Removal from State  '4 Donation 5 Other (Specify)  Lucile Stokes / mother 138 Bay Ridge Rd. Annapolis, MD  20b. Place of Disposition (Name of cemetery, crematory or other place)  Crownsville Vet Cem Apr. 25, 2005 C	21403 ation - City or Town, State rownsville, MD
Balti	permit. Page Department of Important: If any injury or once.		21. Signature of Fuaeral Service Licensee 22. Name and Address of Facility John M. Taylor 147 Duke of Gloucester St. Ann	
1	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, large ling to the line of the lin	Approximate Interval Between Onset and Death
Box 68760,	death certificate be executed e attending physician and id for use as the burial-transit	by Physician/Medical Exa	d	d. Date of delivery
P.O. E	t the c	hysici	1   Yes 2   No 9   Unknown   4   Pregnant at time of death 5   Other (specify)   9   Unknown   9   U	Month Day Year
	w requires that been signed by should be det			o contribute to the cause of death?  No 3 Probably 4 Unknown
Division of Vital Records,	The la ate has page 2	e Completed	25. Was case referred to medical 26. Place of Death. Check onl. one	24b. Were autopsy findings available prior to completion of cause of death?  1 ☑ Yes 2 ☐ No
J of V	di Si	n: To B	Position of the stammer?    Continue	
Division	or Attanditer deatl	Certification:	1 Ta Natural 5 Pending investigation 2 Accident 3 Suicide 4 Homicide 6 Could not be determined 2 building, etc. (Specify) Injury Work?  M 1 Yes 2 No  286. Location (Street and 1 City or Town, State)	Number or Rural Route Number,
	To the Hospital within 24 hours a To the Funeral C completely filled it	edical (		nd manner as stated. lace, and due to the cause(s)
<b>;</b>	To t withi To tl	M	29b. Signature and title of certifier 29d. Date s	20, 2005
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  LING LI, M.D. 111 Penn Street Baltimor	e, Maryland 21201
No.	Sta Registr	2080	O M ACOM - MAGAMAN	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Year 2005 HENRY SPREHE APRIL 22 5:30 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Chesapeake Hospice House Linthicum Anne Arundel | HUnder 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. | 3/31/1925 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year) 1 XM 2 ☐ F 80 Yrs Director 360-24-7405 Illinois Usual Residence of Decedent Pages 1 and 2 should be filled within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or Itams 23a or 28a-f show 10a, State 10b. County 10c. City, Town or Location f Health and Mental Hygiene. Item 27 Is marked other than "natural", or Itams 23a or 28a-f show other traumatic event, Ite Medical Exertings traust Le notified at 10d. tnside City Limits Director 1 Yes 2 □ No Maryland Prince Georges Bowie 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 12415 Stafford Lane 20715 USA Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status MYes 2 □ No f Yes, Give 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed by If Yes, Give Year or Dates: 145-172 Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usuat Occupation
(Give kind of work done during most of working life. DO NOT use retired)
Military
Intelligence Officer 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry United Elementary/Secondary (0-12) Cottege (1-4or 5+) States Army 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Harry Sprehe Regina Going 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Priscilla B. Sprehe/ Wife 12415 Stafford Lane Bowie, MD 20715 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State comotory, cromatory or other place)
Maryland
Veterans Cemetery 1 X Buriai 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. injury or \* 4 ☐ Donation 5 ☐ Other (Specify) 04/28/2005 | Cheltenham, MD 21. Signature of Funeral Sen ce Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician 1len nexa Stor /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physician by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy ò in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown been signed the should be detailed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 1 Yes 2 No or Attending Physician: after death.

Director; After this certific
J in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 2 4 ☐ Nursing Home 5 ☐ Residence 6 2 ther 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Natural tnjury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

Name and address of person

APR 2 A

2005

31. Date filed (Month, Day, Year)

ed cause of death (Item 23a) (Type, Print)

M

egistrar's Signature

		For State Registrar	State of	Marylan		artment rtificate			and M	ental Hy	giene	200	5	1602	7
		1. Decedent's Name (First, Middle, L	ast)							2. Date of Do		Ye		. Time of Deatl	n ,
Physi /Med	ician dical	ALEKSANDRA		SILVERI	BAUM					APRIL		2005		0:25 A	М
Exan	niner	4a. Facility Name (If not institution, gi	ve street and numb	er)		4b. City, To			of Death		4c.	4c. County of Death			
		CASEY HOUSE  5. Social Security Number 6.	Sex 7.	Age (In yrs. I	ast birthday)	ROCK	• •	LE If Under:	24 Hrs.	8. Date of Bi	rth	MONTO			eian
Funera Directo			1□M 2□F	58	Yrs.		Days	Hours	Min.	MAY 24	ay, Year)		Country)	e (State or Fore	ngi i
		Usual Residence of Decedent													_
show		10a. State 10b. County			, Town or Lo									Inside City Lim	
ith the Marylan or 28e-f show	Director	MARYLAND MONTGON	IERY	B1	ETHESD	A 10f. Zip C	Code .				10g. Citi	zen of Wha		Λ.	
with 3e or			VD #30	9			)817					red si			
death	Funeral	11. Marital Status	12. Was Decede	ent Ever in U.	S. 13.		nt of His	spanic Orig	gin? (Spe	cify Yes or N		14. Race - A	American I	Indian,	
after or ite			1 Tes 2	XI No		1 ⊡ Yes 2 <b>)</b>		Specify:	i, rueito	rican, etc.)		Specify:	Vhite, etc.		
ified within 72 hours after death with the Maryland Hygiene. Hygiene then "naturel", or items 23e or 28e-f show ent, the Medical Exercit er mart be mutified.	by by		Year or Date	9S:						<u> </u>	105 (6		WHIT		
in 72 an an	Completed	15. Decedent's 8 (Specify only highest g.	rade completed)		(Give	dent's Usual kind of work DO NOT use	done d retired)	ition <i>luring m</i> ost )	t of worki	ng	160. KI	nd of Busine	ess/indust	try	
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ylaila Kila buld be filed with Mental Hygiene arked other the	Be		t)					18. Mothe	r's Name	(First, Middle	e, Maiden	Sumame)			
should to ind Ment marked umatice	2	JACOB EDII	OVICH						rsyli			ARTEL			
VICE 12 sh h and 7 is m treum		19a. Informant's Name/Relationship		NTD.						I Route Numb					
is 1 and 2 should be filed within 72 hours after death with the Maryla of Health and Mental Hygiene.  If Health and Mental Hygiene is the file after the file and an other treumatic event, the Medical Examinant be mutilied.		ANATOLY SHVARTSMA	IN, HUSDA		lace of Dispo	DEMOCR sition (Name				ate D		SDA , N cation - City			
Pages nent of 1	0	1 M Burial 2 □ Cremation 3 □ 1 4 □ Donation 5 □ Other (Spec		419	emetery, crei DEAN M				/27/	2005	OT.NE	EY, MA	RVT.A	ND	
permit. Pages Department of Importent: If if any injury or or	DCB.	21. Signature of Funeral Service Lice	<i></i>	301	D 22	Name and ANZANS	Addres KY-	s of Facility	ERG	MEMORI	AL C	HAPELS	s, IN		
4026	a	23a Part Enter the disease or con	nolications that can	sed the death	1	170 RC	CKV	ILLE	PIKE	, ROCK	VILL	E, MD	208	52 proximate	
Filmonto		23a. Pa II. Enter the dipease, or con shock, or heart fallurg. List onl Immediate Cause (Final						y, odorras	0474140	· rospiratory t	ATT 001,		Int	erval Between nset and Death	
Physicia /Medica		disease or condition resulting in death)	a	CED OVA		CANCER									
Examine	er	a second participation	h												
p #	ner.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a consequ	ience of:										
ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or	as a consequ	ience of):								-		
ate be executed hysician and the burial-transit	E III			40 4 0011004	301100 017.										
eath certificate be executed attending physician and for use as the burial-transit	edical		Q												
The law requires that the death certific the law requires that the death certific ate has been signed by the attending page 2 should be detached for use as	hvslclan/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me of pregna		Ectopic pred	anancy				2	23d. Date of			
ie deat the att	slole	in the past 12 months?  1 Yes 2 No		nt at time of de		Other (spec						Month	Day	y Year	
that the death cered by the attendir detached for use	0	Part II Other significant conditions	contributing to dea	th but not resu	ulting in the u	nderlying car	ISA AIVA	n in Part I		23a Did	tohacco u	se contribut	e to the c	ause of death?	)
signed	by		contributing to dou	in but not rest	ating in the d	noonying cac	uso givo	erini i garçi.				_	] Probably		
w requir been si should	ompleted			, , , , , , , , , , , , , , , , , , ,						24a. Was		1	autonsv	findings availa	ıble
The lav e has age 2	amo									auto perf	psy ormed?	prior deat	to comple h?	etion of cause No	of
Attending Physicien: The I et death.  rector: After this certificate haby the funeral director, page	O	25. Was case referred to medical						26. Place	of Death	1 ☐ Yes (Check only	2X No one)	, , ,	195 2	1 140	
Physicien: rthis certifica	ToB		Hospital: 1   Inp	atient 2 🗆	ER/Outpatier	nt 3□ DOA	Othe	ar: 4□Nu	rsing Hor	ne 5□Res	idence 6	Other (S	Specity)	HOSPICE	3
ing P				Injury Day Year)	28b. Time o Injury		c. Injury Work	:?	10	28d. Describe	how injur	y occurred			
l or Attending l after death. Director: After in by the funer	Cat	2 Accident investigati 3 Suicide 6 Could not	be 290 Place of	f Injury - At ho	me farm str	M reet factors		/es 2 □ i	-	8f. Location	(Street an	d Number o	r Rural Ro	uite Number	
after Direction	Certification:	4 Homicide determine	building	, etc. (Specify	()	eer, ractory,	OIIICO			City or To	wn, State	)	, , , , , , , , , , , , , , , , , , , ,	, , , , , , , , , , , , , , , , , , , ,	
To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the fune	edical C		Physicien: To the b miner: On the bas and manne	is of examinat	wledge, deat tion and/or in	h occurred at vestigation, i	t the tim	e, date an	d place, a	and due to the	cause(s) date and	and manne place, and	r as stated due to the	d. e cause(s)	
ro the within ro the	Z	29b. Signature and little of certifier	1/2	· stated.		29c.	License	number			29d. Dat	e signed (M	onth, Day	, Year)	
		E ASUM	ev			10 0	141	121	8		4	1261	05	-	
>		30. Name and address of person who CHARLES HARRISON					RO	AD. R	ROCKV	ILLE.	MD :	20852			
Regis	State	31. Date filed (Month, Day, Year)	32 Reg	gistrar's Signa	ture	ule		J I		,					
	_	11111	Julie	100 00											

	1 - Stete Registrer  1. Decedent's Name (First, Middle, La	et)	Ce	rtificate of	Death	2. Date of De.	Reg. No.	005	3. Time of Dea
ian cal		wiesow				April	24°,	2005	8:25P.
ner	4a. Facility Name (If not institution, gine Holy Cross Hospital)				r Location of Deatl r Spring	h	4c.	County of Deat Montgo	
	503–18–9864	Sex 7. Age (In yrs	(last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da Nov. 2,	y, Year) 1924	9. Birt Co Sou	hplace <i>(State or Foi</i> u <i>ntry)</i> th Dakota
or	Usual Residence of Decedent  10a. State 10b. County  Maryland Prince		ity, Town or Lo		· · ·				10d. Inside City Lin
Direct	10e. Street and Number 13024 Ingleside I	Orive		10f. Zip Code 20705				zen of What Co	
by Funeral Director	11. Marital Status 1 □ Never Married 2X Married	12. Was Decedent Ever in the Armed Forces?  1 ☑ Yes 2 □ No If Yes, Give TATATT		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	lispanic Origin? (S an, Mexican, Puert Specify:	specify Yes or No to Rican, etc.)	-	14. Race - Ame Black, White Specify: Wh	e, etc.
Completed b	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. Dece	dent's Usual Occup kind of work done of DO NOT use retired	durina most of wor	rking	16b. Ki	nd of Business/	
	Elementary/Secondary (0-12)	College (1-4or 5+) 5+	Engir			- (5:			overnment
To Be	17. Father's Name (First, Middle, Las. Frederick W. Sc	chwiesow			18. Mother's Nar Martha	ne (First, Middle, H. Pol		Sumame)	
	19a. Informant's Name/Relationship Lorraine V. Schwi	(Type, Print) lesow -wife	19b. Mailii 13024	ng Address (Street l Inglesio	and Number or Ru de Drive	Beltsvi	IIe,	r Town, State, 2 Maryla	nd 20705
	20a. Method of Disposition  1 X Burial 2 □ Cremation 3 [  4 □ Donation 5 □ Other (Speci	Removal from State	comptoni orgi	osition (Name of matory or other place ashington	Cem. 4/2	Date 28/2005		cation - City or lphi, M	Town, State aryland
	21. Signature of Foreral Service Lice	msee Asses	D. 22	2. Name and Addre Dnald V. I	ss of Facility Borgwardt	t Funera	l Ho	me, PA	yland2070
Examiner	23a. Part1. Eta of the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Congestiv Due to (or as a conse Mitral re b. Due to (or as a conse Coronary C. Due to (or as a conse	e heart quence of): gurgita quence of): artery	failure	g, 5001 43 04 ola		1031,		Approximate interval Batwaes Onset and Deat 3 weeks  20 years  20 years
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregr 1 Live birth 2 Fel 4 Pregnant at time of 9 Unknown	tal death 3	□Ectopic pregnancy	,			23d. Date of deli Month	ivery Day Year
by	Part II. Other significant conditions chronic lymphocy		sulting in the u	nderlying cause giv	en in Part I.		obacco u res 2[		the cause of death
Completed						24a. Was autop perfo 1 Yes		prior to death?	topsy findings avail completion of cause 2 \( \text{No} \)
To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 Xnpatient 2	☐ ER/Outpatier	nt 3 DOA Oth	0.00	ath (Check only o		3 □Other (Spec	cify)
	27. Manner of Death  1 XNatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wor		28d. Describe h			
Certification:	3 ☐ Suicide 6 ☐ Could not l 4 ☐ Homicide determined		home, farm, str ify)	reet, factory, office		28f. Location (S City or Tox	Street an vn, State	d Number or Ru )	ral Route Number,
	29a. Certifier 1 Certifying P (Check only one)	hysicien: To the best of my kr miner: On the basis of examin and manner stated.	ation and/or in	vestigation, in my o	pinion, death occu	rred at the time,	date and	place, and due	to the cause(s)
edical	and or a state of southing of	(		29c. Licens	e number		29d. Dat	e signed (Month	n, Day, Year)
Medical	29b. Signature and title of certifier	completed cause of death (Ite A.O. 1400 For 37 Registrar's Sign		D292	193		4/	25/200	5

			1 - For State Registrar	State of Maryla		artment of H		Reg	ene 0 0 5	16029
	Physici /Medio		Decedent's Name (First, Middle, La CELIA STEIN	st)				2. Date of Death	Day 2 2005	3. Time of Death 8:10 AMM
	Examir		4a. Facility Name (If not institution, giv	e street and number)			r Location of Deat	h	4c. County of Death	
	Farmer		7304 Lynnhurst 5. Social Security Number 6. S		rs. last birthday)	Chev	y Chase If Under 24 Hrs	8 Date of Birth	Montgome	
	Funeral Director			□M 2√F 83	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, )	year) Cour 921 MINI	place (State or Foreign ntry) NESOTA
	ryland thow	_	10a. State 10b. County	10c.	City, Town or Lo	ocation			1	Od. Inside City Limits
	8a-1 s	cto	MARYLAND MONTGOME	ERY	CHEVY C					1 X Yes 2 □ No
	with the	Funeral Director	10e. Street and Number 7304 LYNNHURS	r STREET		10f. Zip Code	815		g. Citizen of What Cour ITED STATES	•
	ns 23	ieral	11. Marital Status	12. Was Decedent Ever in	U.S. 13.	Was Decedent of H			14. Race - Americ	can Indian,
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  Important: If time 27 is marked other then "naturel", or items 23a or 28a-f show any injury oprother treumatic event, the Medical Exacting mail be notified at once.	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1	If Yes, specify Cubin 1 ☐ Yes 2 No	an, Mexican, Puerl Specify:	to Rican, etc.)	Black, White,	
2-0	72 hc	eted	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	(Give	dent's Usual Occup	during most of wo	rking 16	6b. Kind of Business/In	dustry
121	within ane. then '	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	d)		GATEG	
ง อ	Hygie Hygie other	ပိ	17. Father's Name (First, Middle, Last,	)	ЕЗ	TALE SALI		me (First, Middle, Ma	SALES uiden Surname)	
<u>lan</u>	Ald be factual frice of	To Be	CARL WITTELS				YETT	I BERNHAU	Γ	
Maryland	2 shou and N is ma euma		19a. Informant's Name/Relationship (	Турө, Print)	19b. Maili	ng Address (Street	and Number or Ru	ural Route Number, C	City or Town, State, Zip	
e` ⊙	and lealth m 27 her tr		JOANNE RUEHL/I				SERVE CI	RCLE, APT	.101, 33624	A, FL
סב	T it it		20a. Method of Disposition  1X Burial 2 Cremation 3	Removal from State	cemetery, cre	osition (Name of matory or other place			c. Location - City or To	
altimore,	artmer prtent injury		<ul><li>4 □ Donation 5 □ Other (Specify</li><li>21. Signature of Funeral Service_Licer</li></ul>			M. GARDEN			LNEY, MARYI	
n	permit. Departr Imports any inj		Donald C.	1 4000					L CHAPEL II ILLE, MARYI	
	Medical be executed // Medical be the prival-transit the burial-transit with the prival-transit medical personal forms of the prival-transit medical personal forms of the prival-transit medical personal forms of the prival for	Ical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, and the cause intermediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Esophagial C  Due to (or as a cons  b.   Due to (or as a cons  c.   Due to (or as a cons  d.	equence of):					Onset and Death 2 Years
O. Box 68	I ne law requires that the death certilicate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknows	23c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time o 9 □ Unknown	etal death 3	Ectopic pregnancy Other (specify)	1		23d. Date of delive	ory Day Year
ds, P	urres tnat i signed by Id be deta	by	Part II. Other significant conditions of	contributing to death but not r	esulting in the u	nderlying cause giv	en in Part I.		cco use contribute to the	
Vital Records,	Ine law requir cate has been si page 2 should I	Completed						24a. Was an autopsy performe	d? prior to cor death?	psy findings available inpletion of cause of
/Ita	ysician: In iis certificate director, pag	Bec	25. Was case referred to medical examiner?			2010		ath (Check only one)		
10	this o	မ	1 □ Yes 2 No	Hospital: 1 Inpatient 2		nt 3 DOA Oth	er: 4 🗆 Nursing H		ce 6 □Other (Specify	1)
ם	After funera	lon:	27. Manner of Death  1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wor	y at k? Yes 2 □ No	28d. Describe how	injury occurred	
DIVISION OF	tor: the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined				.03 2	28f. Location (Stree City or Town, S	et and Number or Rura State)	l Route Number,
	lo the hospitet of Al within 24 hours after of To the Funerel Direc completely filled in by	edical C	29a. Certifier (Check only one)  1 Certifying Ph	i ysician: To the best of my k niner: On the basis of exami and manner stated.	nowledge, death nation and/or in	h occurred at the tir vestigation, in my o	ne, date and place pinion, death occu	, and due to the caus rred at the time, date	se(s) and manner as st and place, and due to	ated. the cause(s)
	vithin 2 To the I	Me	29b. Signature and title of certifier	1		29c. Licens	e number	29d	. Date signed (Month, I	Day, Year)
	10		Lacel	()) Arg		Г	c - 1856	1 Ap	ril 25, 200	05
	(0)		30. Name and address of person who DR. DAVID PERRY				. קוודים מ			
	CA	10	31. Date filed (Month, Day, Year)	PI.D., ITO IKV			, DOTTE (	ZIJI, WAD	TITINGTON D.	
	Sta Registr		APR 2 7 200			E. D				

			1 - For State Registrar		State o		d / Depa		of Hea	lth ar	nd Mental Hy		0.5	16030
			1. Decedent's Name (Fir	rst, Middle, Las	st)						2. Date of De	aath		3. Time of Death
	Physic /Medi Exami	cal	THOMAS D		EXTON	mber)		4b. City, Tov	vn orloc	ation of I	April	26, 20	Year )05 nty of Death	2:15 a <sup>M</sup>
1	LAdiiii	iei	Hartley Hal					Pocom					ester	
	Funeral Director		5. Social Security Number 217–09–6353	er 6. Se		7. Age (In yrs.	last birthday) 4 Yrs.	If Under 1 Y	ear If t	Under 24		th ay, Year)	9. Birth	place (State or Foreign intry) yland
	and		Usual Residence of Dec 10a. State 10b	edent c. County		10c. Cit	y, Town or Lo	cation						10d. Inside City Limits
	Mary a-f sh	tor	MD Wo	orceste	r	Poco	omoke (	City						1 X Yes 2 □ No
	or 28	Director	10e. Street and Number					10f. Zip Co	de			10g. Citizen	of What Cou	ntry?
	s 23a	rail	1006 Market	Stree				2185				US	SA	
21215-0036	s 1 and 2 should be filed within 72 hours after deeth with the Maryland f Health and Mental Hygiene. titem 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, II a Medical Examiliar must be marilial at	by Funerai	11. Marital Status 1 ☐ Never Married 3 ☒ Widowed 4 ☐		Armed Fo 1 X Yes If Yes, Giv	2 🗆 No	'	Was Decedent f Yes, specify 1 ☐ Yes 2 🔀		nic Origin lexican, F pec <i>ify:</i>	n? (Specify Yes or No Puerto Rican, etc.)	Spe	lace - Ameri Black, White, c <i>ify:</i> wh	can Indian, etc. ite
5-0	natu	etec	15. (Specify or	Decedent's Ed	ucation de completed)		(Give	lent's Usual O kind of work d	one durine	g most o	f working	16b. Kind of	Business/Ir	ndustry
2121	within iene.	Completed	Elementary/Secondary	y (0-12)	College (1	-4or 5+)	Sales	00 NOT use re sman	atired)			Whole	sale	
	al Hygir t other vent, I	Be C	17. Father's Name (First,	, Middle, Last)					18.	Mother's	Name (First, Middle			
yla	should be that Mental I marked of umatic eve	To	James T.	Sexto					В	erni	ce McDan	iels		
Maryland	d 2 sh th and 7 Is m traum		19a. Informant's Name/F Art Sexton		ype, Print)						or Rural Route Numb			
	Heal Heal tem 2	1	20a. Method of Disposition			20b. P	lace of Dispo	sition (Name o	f	Hwy ,	, Pocomoke	20c. Locatio		
E O	Page:		1X Burial 2 □ Cre 14 □ Donation 5 □			סומוש ן		natory or other dist. Cen		4/	28/2005		-	ty, Marylan
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		21. Signature of Juneral	Service Licens	600 M		HC	Name and A	Mel:	Facility SON	Funeral Ho Pocomoke	ome, P.	Α.	
			23a. Part1. Enter the dis shock, or heart fails	sease, or comp ure. List only o	olications that cone cause on e	aused the death ach line.								Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	_	a De	ment	ia							Onset and Death  4-years.
п	Examiner			- (	Due to (	or as a consequ	uence of):							
		ner	Sequentially list condition if any, leading to immedicause. Enter Underlying Cause (Disease or injury	ns, iate	b. Due to (	or as a consequ	uence of):	<u></u> .						
	ecute and trans	Examine	Cause (Disease or injury that initiated events resulting in death) Last	)	c									
8760,	cate be executed physician and the burial-transit	icai E	Total III document of the control of	- (	Due to (	or as a consequ	ience of):							
687	ificate g phys			•	d									
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S, D	res that igned b be deta	by Pł	Part II. Other significant	^	/	f		derlying cause	given in l	Part I.	23e. Did t	obacco use co	ntribute to th	ne cause of death?
Division of Vital Records,	w require been sig		Horance	e Hge	+ H	rrhyth	ma				10	′es 2 №No	3 🗌 Prob	ably 4 Unknown
3ec	e law l hes bo	ompieted			-						24a. Was	sy	prior to cor	psy findings available appletion of cause of
alF		e Col	OF Man annu referred to								1 ☐ Yes		death?	2 🗆 No
<u> </u>		0 B	25. Was case referred to examiner?  1 ☐ Yes 2 ☐ No	-	Hospital:	ıpatient 2□I	EB/Outpatient	3□ DOA	04		Death Check only on the second of the second		that /Casait	
n 0	ding Phya T. After this funeral di	J : L	27. Manner of Death	Pending		f Injury n, Day Year)	28b. Time of		njury at Work?	Tu Sii	28d. Describe h			//
sio	Attending ir death. ector: After by the fune	catio	2 Accident	investigation Could not be				M	I □ Yes	2 No				
DIV	i or Atten after deatl Director: i in by the	Certification;	4 Homicide	determined	28e. Place buildir	of Injury - At ho g, etc. (Specify	me, farm, stre	et, factory, offi	сө		28f. Location (S City or Tox	Street and Nun n, State)	nber or Rura	l Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edicai C	(Ollock Olly Z	MACHICAL EXALLI	ner: On the ha	SIS OF AYAMINAT	ion and/or inv	actication in m	W aninian	death c	lace, and due to the occurred at the time,	cause(s) and n	nanner as st	ated. the cause(s)
	To the I	Me	29b. Signature and Mile	certifier (				29c. Lic	ense num	nber		29d. Date sign	ed (Month,	Day, Year)
)			) 2	Salvert				3	)54	42	. 2	4-	260	5
H)	+1		30. Name and address of	person who co	ompleted cause	of death (Item	23a) (Type, F	Print)	MD		21851			
	Sta Registr		31. Date filed (Month, Da	y, Year) R 2 7 20	105 32.	gistrar's Signat	s Ap	ale			2/85/			

			1 - For State Registrar	State of M	larylan		artmen rtificat			and M		Reg.	20	05	16031
	Physici /Medio Examir	al	Decedent's Name (First, Middle, La      Mary I      4a. Facility Name (If not institution, give	Elizabeth Tra			4b. City,	Town, or	Location of	of Death	2. Date of D Month April 2		Day 2005 4c. Count	Year y of Death	3. Time of Death 6:52 AM
	Funeral Director		Holy Cross Hospital 5. Social Security Number 6.3			last birthday) Yrs.	Silve If Under Months	•	ing If Under: Hours	24 Hrs. Min.	8. Date of B	lirth Day, Ye		gomery 9. Birth Cou Virg	place (State or Foreign ntry), 11112
	Maryland	ctor	Usual Residence of Decedent  10a. State 10b. County  DC		1	y, Town or Lo shington									10d. Inside City Limits  V Yes 2 □ No
	ges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Heatth and Mental Hygiene. If item 27 is marked other then "natural", or Items 23a or 28a-1 show or other traumatic event. It we healt a sure it at a matter malified at	Funeral Director	10e. Street and Number 3811 Nash St. SE	12. Was Deceden	t Ever in U.	S. 13.1		020	spanic Orio	gin? (Spe	ecify Yes or N Rican, etc.)		U.S.	What Could	
-0036	hours after or the	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces  1  Yes 2  If Yes, Give Year or Dates:	?  No		1 ☐ Yes	2 X No	Specify:	i, Puerto	Rican, etc.)		Specii	ck, White,	etc. ck
121215	filed within 72 Hygiene. kthar than "ne ant, II e Modic	Completed	(Specify only highest gr Elementary/Secondary (0-12)  17. Father's Name (First, Middle, Lasi	ade completed) College (1-4or 12	5+)	(Give life. I	kind of wo DO NOT us ect Ana	rk done d se retired) 1yst	uring most				NASA		
Maryland 21215-0036	2 should be fi and Mental H Is markad ot raumatic evan	To Be	Robert E. Smith  19a. Informant's Name/Relationship (	Туре, Print)		19b. Mailir	ng Address	(Street a	Bett nd Numbe	y Bur	al Route Num	ber, Cil	y or Town		Code)
altimore, M	Pages 1 and 2 nent of Health int: If itam 27 iry or othar tra		Jewel Graye/Daughte  20a. Method of Disposition  1  Burial 2 Cremation 3  4 Donation 5 Other (Special Property of the Company	Removal from State	9	1762 V lace of Dispo emetery, cren t Lincol	sition (Nan natory or o	ne of ther place	)	0	con, DC 2 Date 2005	20c	Location	- City or To	
Baltin	permit. Pages Department of Important: If is any injury or of		21. Signature of Funeral Service Lice	nsee Coff	iles	3/	Name an	d Address	s of Facility	Fort Bre	Lincoli entwood,	n Fur MD :	neral i		
	Physician /Medical		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	Metastati  Due to (or as	c Mon S	Small Ce				cardiac o	or respiratory	arrest,		4	Approximate Interval Between Onset and Death 4 MONTAS
8760,	icate be executed by physician and physician and si the burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Einer Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. — Due to (or as											
.O. Box 6	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12-months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal	death 3	Ectopic pro							te of delive	ery Day Year
<u>α</u>	w requires that been signed b should be deta	by	Part II. Other significant conditions of Resperator		out not resu	ufting in the ur	nderlying ca	ause give	n in Part I.						ne cause of death? ably 4 [Unknown
Vital Records,	n: The law r ficate has be or, page 2 sh	e Completed	Sepsis  25. Was case referred to medical								1 ☐ Yes	psy ormed 2 X	?	prior to cor death?	psy findings available inpletion of cause of 2 No
Division of Vil	To the Hospital or Atlanding Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	To B	examiner?  1 ☐ Yes 2 ☐ No  27. Manner of Death  1 ☑ Natural 5 ☐ Pending  2 ☐ Accident investigatio	Hospital: 1 Inpati 28a. Date of Inju (Month, Da	ULV	ER/Outpatient 28b. Time of Injury		Bc. Injury Work	4 Nur	sing Hon	(Check only ne 5 ☐ Res 28d. Describe	idence			/)
Divis	oital or Atta urs after dez Iral Directo	Certification;	3 Suicide 6 Could not be determined	building, e	tc. (Specify	')					City or To	wn, Sta	ate)		l Route Number,
	To tha Hospital or within 24 hours after To the Funaral Direction completely filled in I	Medical	29a. Certifier (Check only one)  1 Certifying Pr 2 Medical Example 29b. Signature and title of certifier	nysician: To the best niner: On the basis of and manner st	of examinat	wledge, death ion and/or inv	restigation,	at the time in my opi	nion, deat	d place, a h occurre	and due to the	, date a	ind place,	anner as st and due to d (Month, i	the cause(s)
Λ	E.8 # 8		30. Name and address of person who	completed cause of	Meath (Item	23a) (Tuno 1		D3322					-	25, 20	,
K	- (C) Sta	te	Ram Trhan, MD 50 W.  31. Date filed (Month, Day, Year)	Edmonston Dr	#303 rar's Signat	Rockvil	lle, Mo	1 2085	2						
	Registr		APR 2 8 200	15 Seem	, #	ha	K)								

			1 - For State Registrar	State of Mary		partment of Hertificate of L		•	giene Reg. No. 005	16032
	Physici	an.	1. Decedent's Name (First, Middle, La	•				2. Date of De.	ath Day Year	3. Time of Death
	/Medic			mas				April	27 2005	4.05 PM
	Examin	er	4a. Facility Name (If not institution, giv		1 /1- "	4b. City, Town, or	,	ith	4c. County of Dea	(1)
			5. Social Security Number 6-8	ex 7. Age //n	yrs. last birthda	-	If Under 24 Hrs	s. 8. Date of Birt	Howar	thplace (State or Foreign
Н	Funeral Director			□ M 2√xF 83	Yrs.	Months Days	Hours Min		v, Year) C	ountry)
	p. ,		Usual Residence of Decedent		0: -					
	arylar show	'n	10a. State 10b. County	100	c. City, Town or					10d. Inside City Limits 1 ☐ Yes 2 XNo
	28e-f	Director	MD Howard  10e. Street and Number		Columbi	.a. 10f. Zip Code			10. 0	
	with with a or	Ē				21044			10g. Citizen of What C United Stat	-
	death	era	7013 Longview  11. Marital Status	12 Was Decedent Ever	in U.S. 13	J. Was Decedent of His If Yes, specify Cubar	spanic Origin? (			
9	or Ite	Fur	1 Never Married 2 Married	Armed Forces?				rto Rican, etc.)		te, etc.
203	urel',	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:		Specify: Wh	nite
5-	filed within 72 hours after death with the Maryland Hygiene. ther then *neturel', or tlems 23a or 28e-f show that the Medical Evanination nellied at	Completed by Funeral	15. Decedent's E (Specify only highest gra		16a. Dec (Giv	edent's Usual Occupa re kind of work done d DO NOT use retired;	ition Juring most of wo	orking	16b. Kind of Business	/Industry
12	within ene. then	duc	Elementary/Secondary (0-12)	College (1-4or 5+)		maker	,		Own Home	
9	Hygi Hygi other ent, I	Be Co	17. Father's Name (First, Middle, Last,				18. Mother's Na	me (First, Middle,	Maiden Surname)	
Maryland 21215-0036	should be nd Mental marked c	To B	Harry Cotsonis				Anna	Sohos		
ary	2 should and A ls ma		19a. Informant's Name/Relationship (	Type, Print)	19b. Ma	iling Address (Street a			r, City or Town, State,	Zip Code)
	and 2 ealth n 27 I		Sophia Thomas/Da			Early Apr		Columbia	a, MD 2104	16
Baltimore,	Pages 1 nent of He int: If iter iry or oth		20a. Method of Disposition 1 ☐ Burial 2基 Cremation 3 ☐	Removal from State	Ob. Place of Disposerry, cr	position (Name of ematory or other place	9)	Date	20c. Location - City or	Town, State
ţ	tment tent: tjury		'4 ☐ Donation 5 ☐ Other (Specif	v)	letro Cr	ematory	4/28	/2005	Catonsville	e, MD
Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene 1 in Important: If item 27 is marked other then "neturel", or items 23a or 28e-f show any Injury or other treumatic event, the Medical Evaninar must be neitified at once.		21. Signature of Funeral Service-Licer	1)	0845 4	22. Name and Addres 112 Old Co	<sup>s of Facility</sup> Ha: lumbia	rry H. W Pk. Ell	itzke's Fan icott City,	ully FH, Inc. MD 21043
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that caused the one cause on each line.	death. Do not e	nter the mode of dying	g, such as cardia	ic or respiratory ar	rest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Intro	resebra	1 Henry	ornhag	c		18 h-5.
	Examiner		1	Due to (or as a co	nsequence of):		0			
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. — Due to (or as a co	isequence of,					
	cate be executed physician and the burial-transit	Examiner	that initiated events	c.						
ó	e exerian ar	Exa	resulting in death) Last	Due to (or as a con	nsequence of):					
8760,	ate b	dicai		d						
9 X	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	/Me	IF FEMALE:	23c. If yes, outcome of pr	egnancy	517				
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o.	that the death	nysi	1 ☐ Yes 2 🛣 No 9 ☐ Unknown	9□ Unknown						
ري م	igned t be det	by P	Part II. Other significant conditions of	ontributing to death but no	t resulting in the	underlying cause give	n in Part I.	23a. Did to	bacco use contribute to	the cause of death?
ğ	w require been sig	ted t	Typertensors,	Ceronary	Ack	y Dise	use	1 □ Y	es 2Ho 3Pi	robably 4 Unknown
Records,	has be	Completed	Perkinson	5 Disey	se, Asg.	-chos Pr	121-0-19	24a. Was a		utopsy findings available completion of cause of
		Соп	, *		/			perfor 1  Yes	med? death? 2≦No 1☐Yes	
Viita	icien certifi ector,	Be	25. Was case referred to medical examiner?	Hospital:				ath (Check only or		
o	Attending Physicien: In death. sector: After this certifies by the funeral director.	2	1 Yes 2 No 27. Manner of Death	1 / Inpatient	2 ER/Outpation 28b. Time		4 🗀 Nursing r		ence 6 Other (Spe	cify)
Division of	ting 7. Afte fune	tion	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Yea	ar) Injury	Work	? 'es 2 □ No	200. 00001100 11	ow injury occurred	
N S	l or Attendi after death. Director: A in by the fu	ifica	3 ☐ Suicide 6 ☐ Could not b	28e. Place of Injury	At home, farm, s	treet, factory, office		28f. Location (S	treet and Number or Ri	ıral Route Number,
	tel or s afte el Dir	Certification:	4 Homicide	building, etc. (S)	овсту)			City or Tow	n, State)	
	tospid thour uner uner sly fills	edical	29a. Certifier 1 Certifying Ph	ysician: To the best of my niner: On the basis of exa	knowledge, dea	th occurred at the time	e, date and place	e, and due to the o	ause(s) and manner as	s stated.
	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	Medi	0/10/	and manner stated.	Timation and or					
	To To	~	29b. Signature and title of certifier	/	11 1	29c. License	number 46120		29d. Date signed (Mont	
e.	10	-	1 / Mu		(14)		6160	,	April 27,	2005
E .	8		30. Name and address of person who				6 0	fr	(d.).	10 21044
	<sup>†</sup> Sta	te	31. Date filed (Month, Pay Year)	32. F. gistrar's S	ignature	South &	r 10-	Kury,	Colvabia 1º	10 2044
	Registr	ar	HFR Z 8	Almuse	, K	Anarks				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year JUDITH WARNER TIEDER ADG 15 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner To Sp , You 7. Age (In yrs. last birthday) aston al hot Memorial If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) OCT 29 1935 **Funeral** 6. Sex 9. Birthplace (State or Foreign 1 ☐ M 2 🖔 F Months Days Hours Yrs. MARYLAND Director 220-32-9636 69 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 le marked other than "naturel", or Iteme 23a or 28a-f show other treumatic event, it is Madical Examiner must be notified at 1 ☐ Yes 2 X No Director MD TALBOT EASTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 33 PARK LANE 21601 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: 2 If Yes, Give Year or Dates: Specify:WHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 CASE WORKER STATE OF MARYLAND 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental H Be LLOYD WARNER DOROTHY R. SHUBKAGEL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 26306 ROYAL OAK ROAD, EASTON, MD 21601 SHARON R. SHORTALL/DAUGHTER Itimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State injury or CHESAPEAKE CREMATION CTR. 4/16/2005 STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA
200 S. HARRISON ST., EASTON, MD 21601 Joseph STROWSKI C.F.St. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter ordering Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit and Due to (or as a consequence of): physician Box 68760 certificate be Physician/Medical as the l IF FEMALE use a 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death Dav 5 Other (specify) P.O. detached 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, 3 Probably 4 Onknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes of Vital 2 No 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner 1 Yes 2 No 1 ■ npatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Division Attending Injury 1 Natural 5 Pending death. investigation M 1 ☐ Yes 2 ☐ No after death Director: 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide ŏ Hospital 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 . Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year)

Q

31. Date filed (Month APR) 9

amoni

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician 29, Mary Rose Thompson 2005 11:00 PM April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's St. Mary's Nursing Center Leonardtown If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) April 26, 1940 Maryland Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🗓 F 219-76-2870 65 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 ie marked other than "nother in item 27 ie marked other in item 27 ie marked oth 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2X No Maryland St. Mary's Leonardtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21585 Peabody Street 20650 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 ☐ Married 1 Yes 2K No Specify. Specify: White δ 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry during most of working Elementary/Secondary (0-12) College (1-4or 5+) 8 Disabled Disabled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Joseph Gervase Thompson Mary Agnes Nelson ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sister Elizabeth A. Latham P.O. Box 273 Chaptico, MD 20621 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 3 □Removal from State 1 X Burial 2 ☐ Cremation St. Joseph's Cemetery May 3, 2005 Morganza, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Lic 22. Name and Address of Facility
Mattingley-Gardiner Funeral Home, P.A.
P.O. Box 270 Leonardtown, MD 20650 nen 23a. Part1 Enter the disease, or complications that caused the death. Do not enter by shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mode of dying, such as pridiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a c **Examiner** Sequentially list conditions, if any, leading to initial adjete cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death Month Year in the past 12 months? Day 5 Other (specify) ☐ Yes 2 ☐ No 9☐ Unknown 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 No to the Hospitei or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Tyes 2 📆 No this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a 29a. Certifier 👺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and planner stated. (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

MAY 0 2

James P.

31. Date filed (Month Day, Year)

Jarboe,

M.D

2005

**ORIGINAL** 

cause of death (It 4 23a) (Type, Print)

24035 Three Notch Road, Hollywood, Maryland 20636

State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Dav Year SURINDER K. VERMA APRIL 2005 /Medical 26, 2:15 A 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death 9513 WOODBERRY ST. PRINCE GEORGES SEABROOK If Under 1 8. Date of Birth (Month, Day, Year) 5. Social Security Number Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) Days Months Hours Min. 1 M 217 F Yrs. 578-98-7113 Director 66 FEB. 4, INDIA Usual Residence of Decedent death with the Maryland 10b. County 10c, City, Town or Location ral, or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No PRINCE GEORGES MD. SEABROOK 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9513 WOODBERRY ST. 20706 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hyglene. ant If item 27 is marked other then "natural; or ite any or other traumalic event, it a Madicial Entailmanty or other traumalic event, it is Madicial Entailmanty. 1 Never Married 2 Married 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 【No Specity: ģ Specify: 3 Widowed 4 Divorced Year or Dates: ASIAN INDIAN Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ REGISTERED NURSE NURSING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ပ BHAGAT RAM RAMPIARI 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SUJATA K. VERMA/DAUGHTER 9513 WOODBERRY ST., SEABROOK, MD. 20706 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) permit. Page Department of Important: If eny injury or once. CHAMBERS CREMATORY 4-30-2005 RIVERDALE, MD. 21. Signature of Funeral Service Liversee 22. Name and Address of Facility
CHAMBERS FUNERAL HOME & CREMATORIUM, P.A. M00091 5801 CLEVELAND AVE., RIVERDALE, MD. 20737 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** GLIOBLASTOMA MULTIFORME /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Under ying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): the death certificate be executed attending physician and for use as the burial-trans Due to (or as a consequence of): P.O. Box 68760 Physician/Medicai as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) detached the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ğ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed been 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA 2 1 ☐ Yes 2 🗙 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 1 Natural 2 Accident 5 Pending investigation death. s after death 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specily) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital c within 24 hours af To the Funeral D 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) a visol D31506 APRIL\_26, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANITA AGGARWAL, M.D. 110 IRVING ST. N.W., WASHINGTON, D.C. 20010 31. Date filed (Month, Day, Year) . Registrar's Signature State APR 2 8 2005 Registrar

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	- te	M	1. Decedent's Name (First, Middle, La	st)		1		2. Date of Dea	ath		3. Time of Death	
rail	Physici /Medic		ElliNOR .	O. VAN	GEE			ADRI /	26,			
7	Examir		4a. Facility Name (If not institution, give	D 11		4b. City, Town, o	r Location of Death		4c. C	ounty of Death	,	
	and the second		MANOR CARE		7	13E+h	ESCIA HIDDER	100	YY	JONTS	OMERY	
45	Funeral Director		5. Social Security Number 6. S 1 263-58-6909	M 2∭ F 7. Age (in yrs	last birthday)	Months Days	Hours Min.	8. Date of Birt (Month, Day Mar 4,	y, Year)		ace (State or Foreign ry)	
			Usual Residence of Decedent				<u> </u>	Mar 4,	1909	Germa	illy	
	arylar	_	10a. State 10b. County	10c. C	ity, Town or Lo	ocation				100	d. Inside City Limits	
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	death ms 2%	<b>Funeral Director</b>	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13.		lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	USA 14	Race - America		
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Jai	should be and Mental marked o	ToE	Albert Liebmann				Hedwig K	uoch				
Maryland	C1 cg 750 150		19a. Informant's Name/Relationship (	Type, Print)	19b. Maili	ng Address (Street	and Number or Rur	al Route Numbe	r, City or T	own, State, Zip C	iode)	
	1 and Health em 27 ther tr	1	Cornelia Schweigle 20a. Method of Disposition	er/daughter	5731	26th Str	et NW Wa					
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Baltimore,	permit. Pag Department Important: eny injury c		<ul><li>4 □ Donation 5 □ Other (Specify</li><li>21. Signature of Funeral Service Licet</li></ul>			1 Cremato				ton, Mar		
Ba	Depa Impo eny i		Bove Und Hi	144	)1251 B	oing Home	ss of Facility Crematic	on Servi	ice I	P.O. Box	784 • MD 21029	
谢			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that caused the dea	th. Do not ent	er the mode of dyin	g, such as cardiac	or respiratory ar	rest,	1	Approximate nterval Between	
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Вох	death certifica e attending ph d for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta		Ectopic pregnancy			230	d. Date of delivery		
0.	t the dea by the at tached fo	/slcl	1 Yes 2 No 9 Unknown	4☐Pregnant at time of o	death 5□	Other (specify)				Month D	ay Year	
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Ö	s been si	Completed	Domens	Ja,				24a. Was a	an 2	24b. Were autops	y findings available	
	The tay ate has page 2	E O						autops perfor	SV	prior to comp death? 1 \(\sum \text{Yes} \) 2	pletion of cause of	
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o	Physician: r this certific ral director,	Z .	1 ☐ Yes 2 No		ER/Outpatien	at 3□ DOA Oth	er: 4 Nursing Ho	me 5 Resid	ence 6	Other (Specify)		
	ding P h. After t funera	on:	27. Manner of Death  ☐ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wor	ζ?	28d. Describe h	ow injury o	ccurred		
Division	death ctor: , the i	cat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		ome farm etc		Yes 2 □No	20f Location (C	trant and A	Number or Rural F	Davida Africa	
≥	after after Dire	Certification:	4 ☐ Homicide determined	building, etc. (Special	fy)	eet, factory, office		City or Town	n, State)	iumber or Aurai F	route Number,	
	e Hospital or Attending 24 hours after death. e Funeral Director: After letely filled in by the fune		29a. Certifier Certifying Ph	ysician: To the best of my kno	owledge, death	occurred at the tin	ne, date and place,	and due to the c	ause(s) an	d manner as stat	ed.	
	- 0 - 0	Medical	one) 2   Medical Exam	niner: On the basis of examina and manner stated.	ation and/or in	vestigation, in my of	oinion, death occurr	ed at the time, d	late and pla	ace, and due to th	ne cause(s)	
	To the To the comple	2	29b. Signature and title of certifier	dh An		29c. License	TZL91	2	29d. Date	igned (Month, De	1y, Year)	
R	C			T VI.	/		11001		T	10011. 7	-0 · WUS.	
- 1	3c		30. Name and a ress o person who o	completed cause of death (Iter	m 23a) (Type, 3 20 🔎	emolran	Blud,	Bethe	esda,	MD . 21	9y, Year) 26 · 2005. 0817.	
16	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature		)					
	Registra	ar	APR 2.8	2005 Maser	15	made)						

			For	State of Marylar		ent of Health and	Mental Hygie	ne 2005	1.000
			State Registrar		Certific	ate of Death	Reg.	No.	1003
	Physici /Medic		1. Decedent's Name (First, Middle, Last)  William Henry	21/	Wilkins			Day Year	3. Time of Death  3. 15. A M
	Examin		4a. Facility Name (If not institution, give s	tradit and number) Care Cent	er 4b. 0	ity, Town, or Location of Deat	h	Charles	
	. Funeral Director		5. Social Security Number 6. Sex 239 - 48 - 1782	M 2□ F 7. Age (In yrs.	last birthday) If Un Yrs. Mont	der 1 Year If Under 24 Hrs hs Days Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birthp 7, 1934 Rope	lace (State or Foreign try) PC
	ryland thow		Usual Residence of Decedent  10a. State 10b. County	10c. Ci	ty, Town or Location			1	0d. Inside City Limits
	r 28e-f s	Director	Macybrol Charle	25	JA CUTT 101.	Zip Code	10g.	Citizen of What Coun	
	sath with	erai D	12536 Mirkus	od Lh 12. Was Decedent Ever in U	S 13 Was De	2060 ecedent of Hispanic Origin? (S	Specify Yes or No-	USA 14. Race - America	an Indian
980	72 hours after death with the Maryland Internal; or Items 23c or 28e-f show Jisal Examinar must be notified at	by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 □Yes 2 ☑No tf Yes, Give Year or Dates:	If Yes,	specify Cuban, Mexican, Puer s 2 No Specify:	to Rican, etc.)	Black, White,	etc.
21215-0036	in 72 hours n "netural", tedical Exa	Completed	15. Decedent's Edu (Specify only highest grade	completed)	16a. Decedent's U (Give kind of life. DO NO	Isual Occupation work done during most of wo T use retired)	rking 16t	. Kind of Business/Inc	dustry
	ba filed within 72 ho ntal Hygiene. od other than "netur event, Inv M. circal		Elementary/Secondary (0-12)  12  17. Father's Name (First, Middle, Last)	College (1-4or 5+)	Kruck	Driver 18 Mother's Na	me (First, Middle, Mai	aste MA	nage ment
Maryland	2 should ba f and Mental H le marked of sumatic eve	To Be	Debro		Wilkins	Edna		Mc Collo	nsh
	lith ar 27 le		19a. Inf. mant's Name/Relationship (Ty. Uvonne B. Will	Kins- Wife	19b. Mailing Add	Mirkusod Z	ural Route Number, Ci	ity or Town, State, Zip	10 20601
Baltimore,	Pagas 1 ar nent of Haa int: If item iry or othe		20d. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ R  4 ☐ Donation 5 ☐ Other (Specify)		Place of Disposition (cometery, crematory)	Name of or other place)	2/05 h	Location - City or To	m, State
Balti	permit. Pagas Department of Important: If i any injury or once.		21. Signature of Otheral Service Licens		191 AJAV	and Address of Facility	one PA	Aguares	MI) 20608
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final	cations that caused the dea re cause on each line.				- Oncid	Ap oximate Interval Between Onset and Death
1	Physician /Medical Examiner		disease or condition resulting in death)	Due to (or as a consec		IIC LATE	CAC SCZ	-CKU3/3	mo HTHI
	sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	quence of):				
30,	cate be executed physician and the burial-transit	i Examiner	that initiated events resulting in death) Last	Due to (or as a consec	quence of):				
68760,		Medicai		1					
O. Box	law requires that the death cartificate been signed by the attending I	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregn 1□Live birth 2□Fet 4□Pregnant at time of 9□Unknown	al death 3 □Ectop	ic pregnancy r (specify)		23d. Date of delive Month	ery Day Year
0_	ires that I signed by d be deta	by	Part II. Other significant conditions con	ntributing to death but not re	sulting in the underlyi	ng cause given in Part I.		co use contribute to the	
Records,	e law requir has been si je 2 should l	Completed					24a. Was an autopsy	prior to co	psy findings available mpletion of cause of
<u>س</u>	Th ate						performed 1 ☐ Yes 2 🕅	death? No 1 ☐ Yes	2□No
Vital	Phyeician: The this certificate ral director, pag	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	fospital:	TER/Outpotiont 20		ath <i>(Check only one)</i> Home 5☐ Residenc	a 6 Dother (Specif	4.1
of		H	27. Manner of Death	1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how		7)
Division	Attendin death. ctor: Aft	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At I	M nome, farm, street, fa	1 ☐ Yes 2 ☐ No		t and Number or Rura	al Route Number,
<u>S</u>	To the Hospitel or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune		4   Homicide	building, etc. (Spec			City or Town, S		
	the Hos hin 24 ho the Fun npletely f	Medical		ner: On the basis of examin and manner stated.	ation and/or investiga	rred at the time, date and place tion, in my opinion, death occ	urred at the time, date	and place, and due to	o the cause(s)
	To t To t	Z	29b. Signature and title of certifier			D 44436		Date signed (Month,	
0	121		30. Name and address of person who co	ompleted cause of death (Ite	m 23a) (Type, Print)	D44436 PAULMellow	LIA	Dancam	120600
·	St Regist	ate rar	ASHVIN CUM AS 31. Date filed (Month, Day, Year) APR 282	32. Redistrar's Sign	ature &	le	_ wr	CD UI CA TO Los	,_,_,_

		Stata Registrer				tificate			arica ivi	lental Hy	Reg. No.	200	15	16	038
Physicia /Medica	n	1. Decedent's Name (First, Middle, Last) 01a M. Wooldr:								2. Date of De Month April	ath Day 23	20	83 <u>r</u>	3. Time o	of Death ) P M
Examine		4a. Facility Name (If not institution, give	street and number)			4b. City, 7	Town, or	Location of	of Death		4c. (	County of	Death		
		5222 Hermit P		o (le um le at hi	mth ede )	If Under		1umb		0 D-1( Di-			ard		
Funeral Director	Ì	5. Social Security Number 6. Sec. 127-18-8041	M 2√2 F 7. AG	je (In yrs. last bii 96	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da Sep. 14	y, Year)	08	Coun Nori	lace (State try) Can	or <i>Foreig</i> n colina
		Usual Residence of Decedent								Dopt -	.,				
e Marylan 8e-f show tiffed at	ctor	10a. State 10b. County Virginia		10c. City, Tow	m or Loc	ation		Rich	mond	1			1	0d. Inside 0	City Limits s 2 ☐ No
or 28	Dire	10e. Street and Number				10f. Zip					10g. Citiz	en of Wha		•	
s 23e	erai	1906 Fairmon	t Ave.  12. Was Decedent	Ever in II S	12.14	Van Daned		23223		noity Van ar Na	. 1	Unit		States	3
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or Items 23a or 28e-1 show any injury or other treumatic event, the Medical Exam set must be notified at once.	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 X If Yes, Give Year or Dates:		4	Yes, spec			gin (Spe i, Puerto	ecify Yes or No Rican, etc.)			White,		
ithin 72 ho ne. nen netu	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or:		(Give I	ent's Usua kind of wor OO NOT us	k doné d e retired)	uring most		ing	16b. Kin	d of Busin		•	
led w lygier her th		12th				Tra	in D	etail		/Fina baidul	Advisor		riva	ate	
ould be fi Mental F narked ot natic ever	To Be	17. Father's Name (First, Middle, Last) Samuel						- ,		Annie V	Willi	ams			
and 2 sh salth and n 27 Is m er treum		19a. Informant's Name/Relationship (Ty Cynthia Greene		195						Ellico				21042	2
Pages 1 nent of He ont: If iter ory or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ P 1 1 ☐ Donation 5 ☐ Other (Specify)	lemoval from State	20b. Place o cemete	ry, crem	atory or ot	her place	1		9/2005		ichmo			
permit. Departm Importe any inju		21. Signature of Funeral Service License	Stream	TIT	22.	Name and	d Addres	s of Facilit	y St	ewart F	unera	al Ho	me		
Physician /Medical Examiner		23a. Part1. Unler the disease, or complishock, priheart failure. List only or immediate Ceuse (Final disease or condition resulting in death)	ne cause on each l	d the death. Do ne. erioscle a consequence	not ente	er the mode	of dying	, such as	cardiac o					Approxima Interval Be Onset and 40 y	tween Death
ate be executed hysicien and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a consequence											
that the death certific led by the attending p detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	3c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death		Ectopic pre Other (spe					2	3d. Date o		-	Year
quires that in signed build be deta	þ	Part II. Other significant conditions con Atrial fib	_	-	in the un	derlying ca	ause give	n in Part I.		23e. Did t		v		e cause of ably 4 □	
The law ate has b page 2 st	Completed							-		24a. Was autor perfo 1 ☐ Yes		24b. Wei prio dea 1 🗆	re autor or to con th? Yes	psy findings apletion of	available cause of
ysiclen: is certific director,	Be (	25. Was case referred to medical examiner?								Check only o	one)		Ξ.		25
Shys this al dii	2	27. Manner of Death 1 🛣 Natural 5 🗆 Pending	fospital: 1  Inpati 28a. Date of Inju (Month, Da	ent 2 ER/Ou iry 28b.	utpatient Time of Injury	_	Bc. Injury Work	at		me 5 Resident			(Spios,	ted L	iving
i gitte	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of In building, e	jury - At home, fa tc. (Specify)	arm, stre			65 2		28f. Location (S City or Tox	Street and wn, State)	Number (	or Rura	l Route Nur	nber,
e Hospitel 124 hours a e Funerel t letely filled	edicai C	29a. Certifier (Check only one) 14 Certifying Physical Exami	sician: To the best ner: On the basis of and manner st	of examination ar	e, death	occurred a estigation,	at the tim in my op	e, date and inion, deat	d place, th occurr	and due to the ed at the time,	cause(s) a	and mann place, and	er as st	ated. the cause(	s)
To the within 2 To the comple(	Me	29b. Signature and title of certifier	101			29c.	License	number			29d. Date	signed (/	Month, I	Day, Year)	
(2)		30. Name and oddress of person who co	Merine	e Eus	(Type !	Print\	Ι	3624	6		Ap	ril 2	26,	2005	
161		Robert Olwine,		06 Hammo			C <sub>1</sub>	ite 1	r_2	Brook1	un D	ark	MD	2122	5

DHMH 17 Rev 1/2001

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State Registrar 31. Date filed (Month, Pay Year) APR 2 0

ORIGINAL

32. Poistrar's Signature

			1 = For State Registrer		of Maryland		artment of H		nd Mental H	ygiene Reg. No	4000	16041
	Physic	an	Decedent's Name (First, Midd						2. Date of D	eath Da	y Year	3. Time of Death
	/Medi		Tarlton Exander W						May	5	2005	5:00 P. M
4	Exami	ner.	4a. Facility Name (If not institution	n, give street and nu	ımber)		4b. City, Town, or	Location of	Death	4c.	County of Death	
			24888 Three Notch 5. Social Security Number	Road 6. Sex	7 4 // /	16:44	Hollywood		A Ura		t. Mary's	
a	Funeral Director		220-28-7185 Usual Residence of Decedent	1 <b>X</b> M 2 □ F	7. Age (In yrs. las	Yrs.	If Under 1 Year Months Days	If Under 2- Hours		Day, Year)	Cou	place (State or Foreign htry) and
	fand		10a. State 10b. County		10c. City,	Town or Lo	cation					Od. Inside City Limits
	Man, -fsh	ţō	Maryland St. Ma	rvie	Ho1	.1ywood						1 ☐ Yes 2√2 No
	n the	Director	10e. Street and Number	., .	noi	. ry wood	10f. Zip Code			10g. Cit	izen of What Cour	ntrv?
	th wit	aiD	24888 Three Notch	Road			20636			USA		•
Maryland 21215-0036	iges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28e-f show or other traumatic event, the Madical Examinar must be natified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Mar  3 □ XWidowed 4 □ Divorced	ned 1 X Yes	2 □ No ive		Vas Decedent of Hi f Yes, specify Cuba □ Yes 2 No	spanic Origi n, Mexican, Specify:	n? (Specify Yes or N Puerto Rican, etc.)		14. Race - Americ Black, White,	can Indian, etc. ite
Ò	2 ho	ted	15. Deceder	t's Education	1	16a. Deced	lent's Usual Occupa	ition		18b. Ki	nd of Business/In	dustry
2	thin 7	Completed	(Specify only highe Elementary/Secondary (0-12)	st grade completed) College (	1-4or 5+)	(Give lite. L	kind of work done of OO NOT use retired,	uring most o	of working			auotty
7	ed wii	Con	12			Ste	amfitter			Un	ion	
n D	tal H d oth	Be	17. Father's Name (First, Middle,	Last)				18. Mother's	s Name (First, Middle	e, <i>Maid</i> en	Sumame)	
<u>\}</u>	ould Men varke	J.	Tarlton Exander W						irginia Puro			
a a	12 sh h and 7 is m raum		19a. Informant's Name/Relations			19b. Mailin	g Address (Street a	n <i>d Numb</i> er	or Rural Route Numi	ber, City o	r Town, State, Zip	Code)
	1 and Healt em 2 ther		LouAnn Lindgren/D 20a. Method of Disposition	aughter	20h Plac	5591 H	untingtown isition (Name of	Road, H	unting town,			
altimore,	permit. Pages 1 av Department of Hea Important: If item any injury or other once.		1 Burial 2 Cremation			etery, crem	natory or other place		Date		cation - City or To	
턡	it. Partiment		*4 ☐ Donation 5 ☐ Other (S		Char1		orial Garde	ns Ma	ay 11,2005	Leon	ardtown, M	aryland
Ba	permit. Departm Importa any inju		In ichael Kee	in Hard	ener )	- N	'.O. Box :	y-Gard 270 Le	iner Fune onardtown	· MD	Home, P.A 20650	Α.
П			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that only one cause on	caused the death. I	Do not ente	or the mode of dying	, such as ca	rdiac or respiratory a	arrest,		Approximate Interval Between
}	Physician		Immediate Cause (Final disease or condition	a lu	ma	Car	ucel					Onset and Death
	/Medical Examiner		resulting in death)	Due to	(or as a consequen	nce of):						
		_	Sequentially list conditions, if any leading to immediate	b		ans wante						
	led isit	Examiner	cause. Enter Underlying Cause (Disease or injury	- Male to	(ur as a consequan	ma orj:						
•	and al-trar	xan	that initiated events resulting in death) Last	c. Due to	(or as a consequen	ice of):						
98760	icate be executed physician and s the burial-transit				(						1	
89	ificate g phy: as the	edical		0.								
O. Box	requires that the death certificate be executed een signed by the attending physician and hould be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live t	tcome of pregnancy pirth 2 Petal de nant at time of death pown	ath 3	Ectopic pregnancy Other (specify)			2	3d. Date of delive Month	ry Day Year
S,	res that igned b be deta	by Ph	Part II. Other significant condition	ns contributing to d	eath but not resulting	ng in the un	derlying cause giver	n in Part I.	10 - 2	<i>r</i>	se contribute to the	e cause of death?
ecords,	w requir been si should I	ted							¹×	Yes 2	]No 3 ☐ Proba	ably 4 Dunknown
r	The law ate has b page 2 si	Completed							24a. Was auto perfo 1 🗆 Yes	an psy prmed? 2 No	24b. Were autop prior to com death? 1 \( \subseteq Yes	osy findings available apletion of cause of
VII al	nysician: Th iis certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Out -		Death (Check only o	one)		
ō	Phys this ral dii	5	1 Yes 2 No	28a. Date	npatient 2 ER/	-		4   Nursii	ng Home 5 X esi			)
DIVISION	tanding Ph leath. tor: After thi the funeral	ertification;	1 Natural 5 Pendin 2 Accident investig 3 Suicide 6 Could r	g (Moni	th, Day Year)	b. Time of Injury	28c, Injury a Work? M 1 □ Yo	at es 2⊡No	28d. Describe	how injury	occurred	
2	itel or At irs after o ral Diracl led in by	Certifi	4 Homicide determ	ned 286. Place	of Injury - At home ng, etc. (Specify)	, farm, stre	et, factory, office		28f. Location (. City or To	Street and wn, State)	Number or Rural	Route Number,
	To the Hospitel or Attanding within 24 hours after death.  To the Funeral Diractor: After completely filled in by the funer	ledicai	29a. Certifier 1 Certifyin (Check only one)	- Adminion . On the Di	best of my knowled asis of examination her stated.	dge, death and/or inve	occurred at the time estigation, in my opin	, date and p	place, and due to the occurred at the time,	cause(s) a date and p	and manner as sta place, and due to	ited. the cause(s)
	To T Com	Σ	29b. Signature and title of certifier				29c. License		20-1	29d. Date	signed (Month, D	Pay, Year)
				220			H00	557	-21	5	16/05	
			30. Name and address of person of <b>Jennifer Sch</b>	who completed caus				ad C	21ifoi-			
	Sta	te	31. Date filed (Month, Day Year)	S 2005 32.	gistrar's Signatur	1 A	MUCCH RO	au, G	alliornia,	, MD	20619	
	Registra	ar	mni V	0 2003	Contract No.	17						

			•	/ Department of Health and M Certificate of Death		ne 2005	16042
Physic /Med	- X	1 Decedent's Name (First Middle   ast)	JA WAL		HPRIL 2	Day 2005	3. Time of Death 3:43PM
Exami		4a. Facility Name (If not institution, give si SAINT MARYS Ho	OSPITAL	4b. City, Town, or Location of Death LEONARD TOWN  Phirthday) If Under 1 Year   If Under 24 Hrs.		SAINT 1	
Funera Directo		5. Social Security Number  578-28-1330  Usual Residence of Decedent	7. Age (In yrs. last	thirthday) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Yea Apr. 26,	1920 Mary	place (State or Foreign ntry) Land
e Maryland 3a-f show	Director	10a. State 10b. County  Maryland St. Mar		own or Location  Lexington Park	100	Citizen of What Cou	10d. Inside City Limits 1 ☐ Yes 2 No
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Exercitive ment be natified at	by Funeral Dire	10e. Street and Number  22905 Town Creek I  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	Orive  2. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ™ No If Yes, Give Year or Dates:	10f. Zip Code  20653  13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto  1 □ Yes 2 ™ No Specify:	ecify Yes or No-	United St  14. Race - Ameri Black, White  SpecifyBlace	ates can Indian, etc.
21215-0036 ad within 72 hours aft glene. er than "natural", or i, the Medical Exerti	Completed b	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation	16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	ing 16b	. Kind of Business/Ir	
and 21 d be filed wi sntal Hygien ted other th	Be	12 17. Father's Name (First, Middle, Last) John Walton		Cleaning  18. Mother's Nam  Lillia	e (First, Middle, Maid	Mainten den Sumame)	ance
Maryland nd 2 should be file lith and Mental Hy 27 is marked oth	Ţ	19a. Informant's Name/Relationship (Type Elmer M. Rice / So		19b. Mailing Address (Street and Number or Rur 22905 Town Creek Drive	al Route Number, Ci		SECTION OF THE SECTIO
Baltimore, permit. Pages 1 ar Department of Hea Important: if item 3 any injury or other		20a. Method of Disposition  1  Burial 2  Cremation 3  R  4  Donation 5  Other (Specify)	20b. Plac cerr	te of Disposition (Name of letery, crematory or other place)  Mark's UAME Cem. 5-3-2	Date 20c	. Location - City or T	own, State
Balti permit. Departm importa any inju		21. Fun Me License Edward N. Brinsfiel	æ, Jr. M0005		d, Leonar		20650-0279
Physician				Do not enter the mode of dying, such as cardiac			Approximate Interval Between Onset and Death HOURS
ficate be executed in thicate be executed in physician and as the burnal-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque  ATLLEROS CL  Due to (or as a conseque  Due to (or as a conseque		ISEASE		YEARS
Box death cer e attendir of for use	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	3c. If yes, outcome of pregnand 1 Live birth 2 Fetal d 4 Pregnant at time of dea	eath 3 Ectopic pregnancy		23d. Date of deli Month	very Day Year
rds, P.  quires that t n signed by	p	Part II. Dther significant conditions cor	ntributing to death but not result	ing in the underlying cause given in Part I.	23e. Did tobac 1 ☐ Yes		the cause of death?
I Records, P.O.: The law requires that the cate has been signed by the page 2 should be detached.	Completed				24a. Was an autopsy performer 1 ☐ Yes 2	prior to o	topsy findings available completion of cause of
of Vita Physician this certifi al director	To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		Other	th Check onl one ome 5 Residence 28d. Describe how		cify)
Division at or Attending s after death. It Director: Afte	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, street, factory, office	28f. Location (Stree City or Town, S		ral Route Number,
Division To the Hospital or Attending. within 24 hours after death. To the Funeral Director: Alter completely filled in by the funer	Medical C	(Check only 2 Medical Exami	ner: On the basis of examination and manner stated.	ledge, death occurred at the time, date and place on and/or investigation, in my opinion, death occu	rred at the time, date	and place, and due	to the cause(s)
To ti withi To ti	W	29b. Signature in the of certifier	S M.I	29c. License number D61758 23a) (Type, Print) R275 HOSPITAL, L	) A	PRIL Z	8 2005
		30. Name and address of person who come the second	om leted cause of death (Item	23a) (Typa, Print) ARYS HOSPITAL, L	CONAMO.	TOWN, A	AD.
Regi	State strar	31. Date filed (Month, Day, Year) 20	32 Registrar's Signatu	fred			

DHMH 17 Rev 1/2001

		1 - State Registrar	State of Ma	,		tificate of			Reg. No.	2005	16043
ysici: //edic		1. Decedent's Name (First, Middle, L John Louis Welch						2. Date of De	29	, 2005	3. Time of Death 7:50 Am
amin	er	4a. Facility Name (If not institution, g	ive street and number)		ĺ	4b. City, Town,	or Location of Deat	h /		County of Deal	
		Doctors Communit  5. Social Security Number 6.		e (In yrs. /a:	st hirthday)	Lanham If Under 1 Year	If Under 24 Hrs	8. Date of Birt	h	ince Ge	
eral ctor		047-03-4185 Usual Residence of Decedent	1 M 2□F	90	Yrs.	Months Days			y, Year) 914	Conr	thplace (State or Foreign buntry) necticut
14		10a. State 10b. County		10c. City,	Town or Lo	cation					10d. Inside City Limits
any injury or other traumatic event, the Medical Examinar must be notified at once.	Funeral Director	Maryland Prince	Georges	Bowi	Le						1 1 Yes 2 □ No
DE TIO	Dire	10e. Street and Number				10f. Zip Code				en of What Co	ountry?
Take .	rai	2810 Folsom Lane		5	140.1	20715			USA		
Dec	nue	<ol> <li>Marital Status</li> <li>Never Married 2 Married</li> </ol>	12. Was Decedent Armed Forces?		. 13. V	Vas Decedent of f Yes, specify Cut	Hispanic Origin? (S ban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	. 1	<ol> <li>Race - Ame Black, White</li> </ol>	
war	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		45	I□Yes 2∏No	Specify:			Specify: Wh	nite
Eal		15. Decedent's	Education	72 -	16a. Deced	lent's Usual Occu	pation		16b. Kir	d of Business/	
Med	Completed	(Specify only highest g	rade completed)  College (1-4or 5	5+)	life. L	kind of work done DO NOT use retire	during most of wo.	rking			
110	Con		4		Statis	stical A	nalyst		Depa	rtment	of Labor
even	Be	17. Father's Name (First, Middle, Las						me (First, Middle,	Maiden :	Sumame)	
ratic	٦ ر	Louis John Welch					Mary Gu				
traun	14	19a. Informant's Name/Relationship Frances T. Welch	1.7				tand Number or Ru Lane Bowi			Town, State, 2	Zip Code)
ther		20a. Method of Disposition	i/ wile	20b. Pla	ce of Disno	sition /Name of	1	Date Date		ation - City or	Town State
7 01 0		1 X Burial 2 ☐ Cremation 3		cen	netery, cren Mary	natory or other play Land Cemetery	ice)	0.1000=			
injur)		*4 □ Donation 5 □ Other (Spec 21. Signature of Funeral Service Lice		Vet	erans	Cemeter	y = 104/2 ess of Facility $ m Ro$	9/2005 L	Crow	nsville c Funor	e, MD
any		) ///>					apolis Ro				al nome
		23a. Part1. Enter the disease, or co	mplications that caused	the death.						20,13	Approximate
ian		Immediate Cause (Final	ly one cause on each lin	10.				1			Interval Between Onset and Death
cal		disease or condition resulting in death)	a. EVIO	a conseque	L C	01011619	And)	dises	<u></u>		yr S
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		resulting in death) Last	Due to (or as	a conseque	nce of):						
	dicai	•	d	-			-				
000	Physician/Medi	IF FEMALE:	23c. If yes, outcome	of pregnance	21/				11.		
5	cian	23b. Was decedent pregnant in the past 12 months?	1 Live birth 4 Pregnant at	2 Fetal d	eath 3	Ectopic pregnand Other (specify)	у		2:	3d. Date of deli Month	ivery Day Year
	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown	time or dea	5	Ottlet (Specify)_					
		Part II. Other significant conditions	contributing to death be	ut not result	ing in the un	derlying cause gr	ven in Part I.	23e. Did to	bacco us	e contribute to	the cause of death?
detached								1 🗆 Y	es 2 🗹	No 3 □ Pro	obably 4 Unknown
no no delacijed	d by									24b. Were au	topsy findings available
מוסמות הם תפומהוופת								24a. Was a	an l		
V								autop perfor	med?	prior to death?	completion of cause of
or, page 2 should be detached for use as the	e Completed b	25. Was case referred to medical					26 Place of Dec	autop perfor 1 Yes	med? 2 No	prior to c	completion of cause of
N	o Be Completed	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 🗹 Inpatie	nt 2□Ef	R/Outpatient	3 DOA Ot		autop perfor 1 ☐ Yes ath (Check only or	med? 2 No	prior to death?	2 No
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 9:15 A.M Winsky April 24, 2005 Anne /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3310 N. Leisure World Blvd., # 1031 Silver Spring Montgomery 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 K F Director 176-20-8118 PÁ Jan. Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits show il item 27 is marked other than "natural", or Items 23a or 28a-1 sho. græfter traumatic svsnt. The Medical Examiner must be cofficed at 1 ☐ Yes 21 No Director Marvland Montgomery Silver Spring 10f, Zip Code 10g. Citizen of What Country? 3310 N. Leisure World Blvd., # 1031 20906 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 X Widowed 4 ☐ Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental H should be 2 Charles Hritsko Mary Mondiak 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health 20246 Foxboro, Riverview, Michigan 48192 Tim Winsky/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. ' 4 ☐ Donation 5 ☐ Other (Specify) Rock Creek Cemetery 4/27/2005 Washington, DC 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service Licens; 10 East Deer Park Dr., Gaithersburg, MD. 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Extentive Stage Small Cell /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner the death certificate be executed the burial-transit resulting in death) Last Due to (or as a consequence of); Box 68760 physician Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ò in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ pe cate has been signated by page 2 should by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed' 2ENo 2 🛛 No 1 Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5X Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 🔀 No Certification: To funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funeral D 29a. Certifier 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) PaulBan D 60335 April 25, 2005 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul Bannen, M.D., 18111 Prince Phillip Drive, # 327, Olney, Maryland 20832 37 Registrar's Signature 31. Date filed (Month, Day, Year) APR 2 7 State

DHMH 17 Rev 1/2001

Registrar

2005

			For 1 - State Registrar	St	ate of M	arylan		artment rtificate				lental Hy	giene Reg. Nd	200	5	160	145
	Discosio:		1. Decedent's Name (First, Midd	e, Last)								2. Date of De Month	ath Da	y Ye		3. Time of	Death
	Physici /Medio		MARION	В.	WOLF							APRIL	24,	2005	1	1:30	A M
	Examir	ner	4a. Facility Name (If not institution		and number	)				Location of	of Death			. County of [			
			MANOR CARE - Post Social Security Number	OTOMAC 6. Sex	7 40	ne (In vrs	last birthday)	POT If Under	OMA(	If Under:	24 Hrs.	8 Date of Bir		ONTGOM		a (State o	r Foreign
	Funeral Director		060-09-1606	1 □ M		85	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da SEPT 2	y, Year)	19 NI	Birthplace Country) EW YO	)RK	1 Greigir
	ס	1	Usual Residence of Decedent										,				
	arylar show	-	10a. State 10b. County				ty, Town or Lo	cation							10d.	Inside Cit	
	the M	ectc	MARYLAND MONTG  10e. Street and Number	DMERY_		PC	TOMAC	10f. Zip	Codo				10a Cit	izen of Wha	· Country		
	with Ba or	Funeral Directo	10714 POTOMAC	CENNTS	LANE				0854			-		TED S	-		
	ms 2	era	11. Marital Status	12. W	/as Decedent			Was Deced	lent of Hi	spanic Ori	gin? (Spe	ecify Yes or No		14. Race - /	American	Indian,	
9	or its	Für	1 Never Married 2 Mar	ried 1	med Forces' □Yes 2 <b>\</b> Yes, Give			if Yes, spec 1 ☐ Yes 2	-	n, Mexican Specify:		Rican, etc.)			Vhite, etc.		
003	urai',	d by	3 X Widowed 4 □ Divorce	Y	ear or Dates:									Specify:	WHI		
15-	within 72 hours after death with the Maryland ane. than "natural", or items 23a or 28a-1 show in Madical Examinar musi be notified at	lete	(Specify only highe	T	npleted)		16a. Dece (Give	dent's Usua kind of wor DO NOT us	rk done a	turina mosi	t of worki	ng	16b. K	ind of Busin	ess/Indus	try	
21215-0036	with liene.	Completed	Elementary/Secondary (0-12)	C	ollege (1-4or	5+)	ADMIN1	STRAT	CIVE	ASSI	STAN'	Γ	ENC	SINEER	ING		
	e filec al Hyg othe vsnt,	Bec	17. Father's Name (First, Middle	Last)						18. Mothe	er's Name	(First, Middle	Maiden	Sumame)			
ylai	Ments Ments arked	To	ABRAHAM	BERRY						MIN	NIE		SHAI	PIRO			
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants if itsm 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Madical Examiner must be notified at once.		19a. Informant's Name/Relation		ŕ							I Route Numb				de)	
	1 and Healtl sm 27		MICHAEL WOLF  20a. Method of Disposition	- SON		20b. F	Place of Dispo	sition (Nan	ne of			ASHINGT		DC 20 ocation - City		. State	
Baltimore,	S T T S		1  Burial 2  Cremation 4  □Dopation 5 □ Other (		val from State		emetery, cre 'H ISRA	matory or o	ther place	-				BRIDG			DCEV
Ħ	nit. P artme ortan injur		21. Signature of Funeral Service	Licensee		рыт						MEMORIA					KDEI
B	Ded imp gns	İ	1 Janes 1	the	4.1		DA 11	NZANS 70 RC	SKY-( )CKV]	GLLE I	ERG I PIKE	MEMORIA , ROCKV	L CE TLLE	HAPELS E. MD	, INC 2085		
			23a. Part . Enter the disease, of shock, or heart failure. Lis	complicatio	ns that cause use on each I	d the deat									Ap	proximate terval Betv	veen
	Physician		Immediate Cause (Final disease or condition		ORONAR										YEA	nset and $\mathbb{C}$	eath
	/Medical Examiner		resulting in death)		Due to (or as	a conseq	uence of):										
	Examino.	10	Sequentially list conditions,	b. <u>A</u>	THEROV			EASE							YEA	ARS	
	uted I Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	<b>s</b>	INUSIT		,								YEA	AR	
oʻ	exect an and rial-tra	Exa	that initiated events resulting in death) Last	c. <u>-</u>	Due to (or as		uence of):										
8760,	requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transit	Ical		d				· · · · ·									
9	leath certifica attending phi I for use as th	Physician/Med	IF FEMALE:	220 14					_								
Вох	attend for us	clan	23b. Was decedent pregnant in the past 12 months?	1	yes, outcome □Live birth □Pregnant a	2 Feta	ldeath 3□	Ectopic pro						23d. Date of Month	delivery Da	y Y	'ear
P.0.	the dr	ysic	1 □ Yes 2 □ No 9 □ Unknown		Unknown			3 0 11101 (0)01									
	res that the de signed by the a be detached f	by Pi	Part II. Dther significant condit	ons contribu	ting to death I	but not res	ulting in the u	nderlying ca	ause give	en in Part I.		23e. Did t	obacco (	use contribu	te to the c	ause of de	eath?
rds	w require been sig should b											10	Yes 2	□ No 3[	Probably	y 4 ₹ U	nknown
Records,	≥ □ 0	Completed										24a. Was		prior	e autopsy to comple	findings a	available ause of
E B	ding Physician: The lav h. After this certificate has funeral director, page 2	Соп										perfo 1 ☐ Yes	rmed? 2 No	deat	h?	] No	
Vital	Physician: this certific	Be	25. Was case referred to medical examiner?	Hospit	tal:				Othe			(Check only o					
of	Phys r this ral dir	To.	1 ☐ Yes 2X No 27. Manner of Death		1 U Inpati		ER/Outpatier 28b. Time o		/A	4 <u>++</u> Nu		me 5 🗀 Resi			Specify)		
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Division	r Attendi er death. rector: A by the fu	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deten		Be. Place of In	jury - At h	ome, farm, sti	reet, factory	, office			28f. Location (: City or To			r Rural Ro	oute Numl	ber,
	rs after al Direction led in l	Cert															
	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	Medical	29a. Certifier X Certifyi (Check only 2 Medica	Examiner:	n: To the best On the basis of and manner s	of examina	owledge, deat ation and/or in	h occurred vestigation,	at the tim , in my op	ne, date an pinion, dea	d place, a th occurr	and due to the ed at the time,	cause(s) date and	) and manne d place, and	r as state due to the	d. e cause(s)	
	To the To the Complet	Σ	29b. Signature and title of certific	50				29c	. License	number			29d. Da	te signed (N	fonth, Day	, Year)	
•	5		10	Kay	Cu		*		D357	792			APF	RIL 26	, 200	05	
			30. Name and address of pelson SWAROOP G. RA						VF.	ROCI	KVTL	LE, MD	208	352			
	Sta	ate							- 4 11 9	1.001		LID , LID	200	. J			
	Regist		31. Date filed (Month, Day, Year APR 2	7 2005	Baren	w h	J. 199										

	State of Maryland / Department of He		l Hygiene	17016
	1 - State Registrar Certificate of D		Reg. No., UU	3. Time of Death
Physician	KENNETH E. WOOD	Mor		10 70 5
/Medical Examiner	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Li		4c. County of De	
Cxaminer	Suburban Hospital Bethesd	la	Monte	gomery
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Months Days	Hours Min. 8. Date	of Birth 9. B	rthplace (State or Foreign Country)
Director	220-28-5019 LSM 2DF 69 Yrs. Usual Residence of Decedent	Sep	t.29,1935	Wash. DC
/land	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
a-f sh iffied	MD Montgomery. Silver Sprin	ng		Yes 2 No
with the Mar to 28a-1st be notified Director	10e. Street and Number 10f. Zip Code	0.1.0	10g. Citizen of What (	
5-0036 72 hours after death with the Maryland "naturel", or Items 23a or 28a-f show calcul Examiner must be notified at leted by Funeral Director		910	U.S.A	
of ther death virthems 23stalling round Tuneral	Armed Forces? If Yes, specify Cuban,	, Mexican, Puerto Rican, e	tc.) Black, Wh	ite, etc.
O36	3 ☐ Widowed 4 ☐ Divorced If Yes, Give 1 ☐ Yes 2 ② No	Specify:	Specify: B	lack
21215-0( 99/9/9/9/9/9/9/9/9/9/9/9/9/9/9/9/9/9/9	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done dur	ion ring most of working	16b. Kind of Busines	s/Industry
vithin 72 within 72 than "nat	Elementary/Secondary (0-12) 7th College (1-4or 5+) Auto Deta	ailer	Covingt	on Buick
ind 2121 be filed withir tal Hygiene, d other than event, fre M. Be Compl			Middle, Maiden Sumame)	
Aarylanc 2 should be 1 and Mental 1 is marked of 1 is marked of 1 reumatic eve	Jim Wood	Irene	Johnson	
fary 2 sho and h is ma	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and			
Ore, N Ore, N ges 1 and 1 of Health If item 27	Thaddeus W. Johnson (Bro) 8908 Conting 20a. Method of Disposition (Name of	nental Pl.	, Landover,	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filled within 72 hours at Department of Health and Mental Hygiene. Important: If flem 27 is marked other than "naturel", or any injury or other treumatic event, the Marcel Examplence.  To Be Completed by F	1   Burial 2   Cremation 3   Removal from State 1   Donation 5   Other (Specify)  Ash, Memorial Cer			
nit. P. artme ortan injury			N FUNERAL H	
Balti Permit. Departm Importa	Desige Anaud 246 N. Was	sh. St., R	ockville, M	D 20850
7,9	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line.	such as cardiac or respira	atory arrest,	Approximate Interval Between
Physician	Immediate Cause (Final disease or condition a. Metastatic Colon Can	ncer		Onset and Death
/Medical Examiner	resulting in death)  Due to (or as a consequence of):			
7)   2	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
0, executed an and rial-transit	cause. Enter Underlying Cause (Disease or injury that initiated events  c			
00, e exection an unial-tru	resulting in death) Last Due to (or as a consequence of):			
68760, ficate be executed physician and is the burial-transit edical Examir	d			
Box 6 Box 6 leath certific	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of d	alivary
IETH E O+ I Records, P.O. Box 6 The law requires that the death certif the has been signed by the attending bage 2 should be detached for use a	23b. Was decedent pregnant in the past 12 months?  1		Month	Day Year
P.O. at the dat the datached etached	9 Unknown		all years and a second a second and a second a second and	
ds, P.O. I uires that the de signed by the a lid be detached 1 db by Physic dby Physic	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given	n in Part I. 23e	Did tobacco use contribute	
Cord cord wrequire been si should b			1 Yes 2 No 3	
1 Record Il Record The law requir The law requir page 2 should Completed		248	a. Was an 24b. Were prior to performed?	autopsy findings available completion of cause of
Vital Recom	25. Was case referred to medical	1  26. Place of Death (Check	Yes 2 No 1 ☐ Ye	s 2 No
Vision of Vital Records, Vision of Vital Records, Attending Physicien: The law requires to death.  setor: After this certificate has been sign, by the funeral director, page 2 should be diffication; To Be Completed by	examiner?		☐ Residence 6 ☐ Other (Sp	ecify)
n of n of n of n of hy or T on: T	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work?		scribe how injury occurred	-
Siol Siol tendii leath. tor: A the fu	2 Accident investigation M 1 Ye	es 2 No		2 4 2
Division  Division  Division  our attending  uns after  uns birector: Alte  lied in by the fune  Certificatior	4 ☐ Homicide  3 ☐ Suicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		ation (Street and Number or I or Town, State)	Hurai Houte Number,
splitel splitel merel filled	29a. Certifier 1[文Certifying Physician: To the best of my knowledge, death occurred at the time,	, date and place, and due	to the cause(s) and manner	as stated.
Division of  To the Hospital or Attending Physwithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opin and manner stated.	nion, death occurred at the	e time, date and place, and d	ue to the cause(s)
To the within To the comp	29b. Signature and title of certifier 29c. License r		29d. Date signed (Mo.	
15	future of Dan MD D227	775	April	19, 2005
(0	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Frederick G. Barr, M.D. 5454 Wisconsi	in Ave C	hevy Chace	MD
State	Frederick G. Barr, M.D. 5454 Wisconsi	III AVE., C	nevy chase,	-11/
Registrar	31. Date filed (Month, Day, Year)  APR 2 7 2005			

		•	For State Registrar		State of	Marylan		artment of F <i>rtificate of</i>		nd Men		iene og. No 🔿 🦽		
	Physici	an	Decedent's Name (Fire	rst, Middle, Las	t)					_ N	ate of Deat	h C. C	Vear Year	3 Time of Death
	/Media	al	Francis A.					45 City Town		A	pril 2	26, 20	05	8:14 a M
	Examin	er	4a. Facility Name (If not Montgomer					4b. City, Town, o	kville				ity of Death	
	Funeral		5. Social Security Number	er 6. Se	9x 7	. Age (In yrs. I		If Under 1 Year	If Under 2	4 Hrs.   8. E	ate of Birth Month, Day,		9. Birthp	lace (State or Foreign try)
	Director		242-05-3412	-	<b>⊠</b> M 2□F	89	Yrs.	Months Days	Hours	Ju	ne 23	, 1915	North	n Carolina
	and w		Usual Residence of Dec 10a. State 10b	edent c. County		10c. City	, Town or Lo	ocation					10	0d. Inside City Limits
	Mary I-f sh	tor	Maryland	Mo	ntgomery	-	Ro	ckville						1 ☐ Yes 2 <b>/</b> 20No
	th the	Olrec	10e. Street and Number					10f. Zip Code			10	0g. Citizen o	f What Coun	try?
	ath wi	by Funeral Director	13407 Tan	ngier P				2085					USA	
	ter de Items	-une	11. Marital Status 1 ☐ Never Married	2□ Married	12. Was Deced Armed Ford 1 □ Wes 2	es?	S. 13.	Was Decedent of H If Yes, specify Cub	lispanic Origi an, Mexican,	in? (Specify Puerto Rica	Yes or No- n, etc.)		ace - Americ lack, White, o	
036	urs af		3 🗆 XVidowed 4 🗀		If Yes, Give Year or Dat	TATTAT T	I	1 ☐ Yes 2 ☑ No	Specify:			Spec	eify: Whit	е
21215-0036	within 72 hours after death with the Maryland ane. than "natural", or items 23a or 28a-1 show the Medical Exerting the multimal at	Completed	15. (Specify or	Decedent's Ed	lucation de completed)		(Give	dent's Usual Occup	during most (	of working		16b. Kind of	Business/Inc	lustry
121	within ane. than "	mpl	Elementary/Secondary		College (1-4	lor 5+)	life.	DO NOT use retire Control	d)			и с	37	
	filed Hygie other land, III		17. Father's Name (First	t, Middle, Last)	Τ.		TITE	CONCLOT			st, Middle, A	Maiden Suma	. Navy	
Maryland	12 should be filed within? h and Mental Hygiene. 7 Is marked other than " traumatic event, Inc Med	To Be	George A.	Wright	t				Ada	Franc	ces Go	wer		
lan	2 shorand A		19a. Informant's Name/I				1	ng Address (Street			,	,		
	is 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23s or 28s-1 show other traumatic event, the Medical Exertified at		Jeffrey S	<u>_</u>	nt/ Son	20h B	1	7 Tangie:	r Plac	e, Roc				
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other tra		20a. Method of Dispositi	emation 3 🗆		ato Cé	emetery, crei	matory or other pla ven Cemeter		April	30,		n - City or To	
量	artne ortani injury		° 4 ☐ Donation 5 ☐ 21. Signature > Fu era			1000		Name and Addre		2005				g, Maryland
ñ	Depar Depar Impor any ir		) (h	rchew	Alal	Le	5	00 Unive	rsity	Blvd,	W, Si	lver S	Inc. Spring	, MD 20901
68760,	Physician // Medical Examiner as the bural-transit	edical Examiner	23a. Part1. Enter the dishock, or heart fail Immediate Cause (Fina disease or condition resulting in death)  Sequentially list condition fany, leading to immediate. Enter Industry Cause (Disease or injuritat initiated events resulting in death) Last	ons,	a. Adult Due to (o  b. End- Due to (o	Failu: ras a consequ Stage ras a consequ ras a consequ	re to lence of):  Dementence of):	Thrive						Interval Between Onset and Death
O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent preg in the past 12 mon 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	ths?		h 2 ∏Fetal nt at time of de	death 3[	Ectopic pregnancy Other (specify)	/				Date of delive Month	ry Day Year
rds, P.	quires tha an signed I uld be det	by	Part II. Other significant Cerebrovas		-	th but not resu	ılting in the u	nderlying cause giv	ren in Part I.					e cause of death? ably 4 Munknown
al Records,		Completed								_	24a. Was ar autops perform 1 ☐ Yes 2	v	Were autor prior to con death? 1 \( \subseteq \text{Yes}	osy findings available inpletion of cause of
of Vital	Physician: this certifical	Be	25. Was case referred to examiner? 1 ☐ Yes 2 ☒ No	o medical	Hospital:			Ott		of Death (Ch				
o	g Phy er this eral di	n: To	27. Manner of Death		1 ☐ Inj	Injury	ER/Outpatier 28b. Time o		y at			ince 6 XO		Hospice
ion	ttending death. ctor; Aft y the fun	atlo	2 Accident	Pending investigation		Day Year)	Injury		k? Yes 2∐N	lo				
Division	Hospital or Attending 24 hours after death. Funeral Director: After tely filled in by the fune	Certification:	3 Suicide 6 4 Homicide	Could not be determined	200. Flace 0	f Injury · At ho g, etc. <i>(Specif</i> y	me, farm, str	reet, factory, office		28f. L	ocation (Str City or Town	reet and Nun , State)	nber or Rurai	l Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Medical	29a. Certifier 1 (Check only one)	Certifying Ph Medical Exam	ysician: To the b niner: On the bas and manne	is of examinat	wledge, deat ion and/or in	h occurred at the til vestigation, in my o	me, date and pinion, death	place, and on occurred at	lue to the ca the time, da	use(s) and rate and place	nanner as sta e, and due to	ated. the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title	of certifies	1			29c. Licens	e number	10 -	29	9d. Date sign	ned (Month, L	Day, Year)
•	SH		Elle	Ul	w			00	1121	8		4/	2610	5
			30. Name and address of Charles H	arrison	n, M.D.	6001 N	Muncas	ter Mill	Road,	Rockv	ille,	Maryl	and 20	0855
	Sta Registi		31. Date filed (Month, D	2 7 20	105 32 Re	gistrar's Signar	ure do	all						

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Year **Physician** Catherine Betty Walters 3:50 PM May 4 2005 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Beverly Health Care Center Frederick Frederick Frederick If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months | Days | Hours | Min. | (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) n, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🕱 F 214-16-1633 Yrs. July Director 84 1920 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene, 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits s 23a or 28a-f show 1 Yes 2 □ No Director Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 30 North Place U.S.A. 21701 Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ☐ Yes 2 XNo f Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White þ 3 X Widowed 4 □ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Assembly Worker Manufacturing/Electric other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 1 and 2 should be Health and Mental Charles R. Handley Laura V. Stine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 65 nt of Health a Clara E. Hobbs/Sister 13530 Old National Pike, Mt. Airy, MD, 21771 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State ò Important: fi any injury o once. ' 4 ☐ Donation 5 ☐ Other (Specify) Mt. Olivet Cemetery | May 9, 2005 Frederick, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 106 East Church Street Ryan Mª Millian Keeney and Basford P.A. Funeral Home Frederick, MD, 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Division of Vital Records, P.O. Box 68760,义 death certificate be executed Due to (or as a consequence of): buria!physician s the burial Physician/Medical ast attending IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy o in the past 12 months? Month Year Day 4□Pregnant at time of death 5 Other (specify) 1 Yes 2 LINO 9 Unknown Š signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 □Unknown 1 Tyes 2 No Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? page certificate 1 Yes 2 N Attending Physician: rector, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 1 Tes 2 DNO 1 🔲 Inpatient this ( 2 ER/Outpatient 3□ DOA rsing Home 5 Residence 6 Other (Specify) funeral 27. Manner of 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 1 Diffural 5 Pendina 1 ☐ Yes 2 ☐ No investigation М 2 Accident within 24 hours after dea To the Funeral Director 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 1 Destrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier cal and manner stated. 29b. Signature and title of certification 29c. License number est goth 31. Late filed (Month, Day,

State Registrar

2005

		artment of Health and Mental rtificate of Death	Reg. No. 4 UU5   504
Physician /Medical	W+hal	Yount 2. Date of Month Apri	Day Year 12:00 A
Examiner	4a. Facility Name (If not institution, give street and number)  316 Biddle Road  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	4b. City, Town, or Location of Death  Accokeek  If Under 1 Year   If Under 24 Hrs.   8, Date of	4c. County of Death Prince George's
Funeral Director	240-28-2680       1 □ M 2 ☒ F       80 Yrs.         Usual Residence of Decedent         10a. State       10b. County       10c. City, Town or Liverage of the county of the coun	Months Days Hours Min. (Month March	of Birth h, Day, Year) 1 23, 1925  9. Birthplace (State or Foreign Country) North Carolin  10d. Inside City Limits
with the Maryle to or 28a-f shore to or CHI of a Director	W 1 1 5 1		1 Ug. Citizen of What Country?
of the state of th		20607 Was Decedent of Hispanic Origin? (Specify Yes of If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	USA or No- 14. Race - American Indian,
nours after nours after LEran Del	3X Widowed 4 □ Divorced If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puerto Rican, etc 1 ☐ Yes 2 ☑ No Specify:	Black, White, etc.  Specify: White
paritinione; Interpretation Z. I.Z. 13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: if Item 27 is marked other than "netural, or Items 23a or 28a-f show my injury or other traumatic event. The Medical Examinar must be Edited at once.  To Be Commisted by Funeral Director	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)  11 W	ident's Usual Occupation  skind of work done during most of working  DO NOT use retired)  aitress	16b. Kind of Business/Industry  Food Service
Viainu vid be filec Mental Hyg arked otheratic event,	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Mi Bertie Gree	
and 2 sho lealth and m 27 is ma	Carol Worthington Daughter P.O	ng Address (Street and Number or Rural Route N Box 234 Accokeek, MI	20607
permit. Pages 1 Department of H Important: if ite any injury or ott	'4 □ Donation 5 □ Other (Specify) Charles Mem	ortial Gardens May 3, 200  2. Name and Address of Facility Mattingley—Gardiner Fu	
o the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  The Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  The Hospital or Attending physician and within 24 hours at the funeral director; page 2 should be detached for use as the burial-transit and within 25 points.  The Hospital or Attending physician and within 25 points are also provided as the burial-transit and within 25 points.  The Hospital or Attending physician and within 25 points are also provided by Physician Medical Examiner.	Due to (or as a consequence of):  Sequentially list conditions.  Law leading to miniocials cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):	TRUCTIVE PULMONAPY	Interval Between Onset and Death
nat the death certificate by the attending pleached for use as the book of the standard for the same of the same o	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9  Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2  Fetal death 3   4 Pregnant at time of death 5   9  Unknown	□Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day Year
equires that seem signed lould be det	Part II. Duties significant conditions contributing to death but not resulting in the u		Did tobacco use contribute to the cause of death?  No 3 Probably 4 Unknown
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To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page.  Medical Certification: To Be Com	examiner? 1   Yes 25 No   Hospital: 1   Inpatient 2   ER/Outpatier		nt one Residence 6 □Other (Specify) ribe how injury occurred
To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Medical Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	reet, factory, office 281. Location City on	on (Street and Number or Rural Route Number, Town, State)
thin 24 hour thin 24 hour the Funer empletely fill	29a. Certifier (Check only one)  Check only one	vestigation, in my opinion, death occurred at the ti	the cause(s) and manner as stated, me, date and place, and due to the cause(s)
S T WE S	Jezen ""	29c. License number  28 28 1	29d. Date signed (Month, Dey, Year)  APRIL 29, 2005
10		Print) Industrial Park Dr. Waldorf,	, MD 20602
State Registrar	31. Date liled (Month, Day, Year)  MAY 0 2 2005  32. Registrar's Signature	all I	

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - State AMEND#5perINF,5/5/05, HW, McCo Certificate of Death Rag. No: 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 26, 2005 3:30am April Georgann Young /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Mariner Health of Bethesda Bethesda Montgomery Hours Min. 8. Date of Birth (Month, Day, Year)
Apr. 22, 19 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, If Under 1 Year Social Security Number 216-40-7734 6. Sex Days **Funeral** 1 □ M 2 🕱 F Yrs 1943 Ohio 62 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10b. County 10c. City, Town or Location 10a, State item 27 is markad other then "natural", or items 23a or 28e-f shov other treumatic event, the Madical Examinar must be rediffed at 1 ☐ Yes 2 🐴 No Director Ijamsville Maryland Frederick 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number death with 21754 United States 2743 Loch Haven Drive Funerai 14 Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. In item 27 is marked other then "natural", or fler eny intry or other treumatic event, Ite Marital Examinat one. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Š White 3 ☐ Widowed 4 😿 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Waitress Restaurant 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Doris Porter ပ George Young 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11287 Woodhaven Drive, Ijamsville, MD 21754 James David Clark (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crematory 4/26/2005 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) DeVol Funeral Home 22. Name and Address of Facility Name and Address of Facility

East Deer Park Drive

Thorsburg, MD 20877 21. Signature of Funeral Service Licensee Gaithersburg, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician Coronary Artery Disease /Medical Due to (or as a consequence of) **Examiner** Renal Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Failure to Ihrive Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy 1 Live birth Year Month Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 🗷 No the detachad 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No has 2□No 1 ☐ Yes To the Hospitel or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 🙀 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 1 ☐ Yes 2 🔀 No 2 this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: After Injury 1 X Natural 5 ☐ Pending after death.

I Director: At din by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide in by determined 4 Homicide 24 hours a le Funarel I 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of confifier April 26, 2005 D 51280 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9715 Medical Center Drive, #201, Rockville, MD 20850 Anushiravan Dadgar, M.D., 324Registrar's Signature 31. Date filed (Month, Day, Year) State APR 27 2005 Registrar

DHMH 17 Rev 1/2001

			For State Registrar	State of	of Marylar	•	artment of H			l Hygier	2000	16051
		Fi	Decedent's Name (First, Midd	le, Last)						of Death		3. Time of Death
	Physici /Medic		Erma R. Amrh	nein					M		Pay Year	
	Examin		4a. Facility Name (If not institution	_			4b. City, Town, or				c. County of De	eath
			Union Memor	ial Hospi		(n at birth days)	Balt If Under 1 Year	imore		of Dirth	100	Cidhalas (Chan Fair
	Funeral Director		5. Social Security Number 214-14-9300	1 ☐ M 2 🂢 F	7. Age <i>(In yr</i> s. 82	Yrs.	Months Days	Hours		of Birth oth, Day, Yea 28, I	922 M	Birthplace (State or Foreign Country) aryland
	ס		Usuel Residence of Decedent				`					
	srylan	-	MD 10a. State 10b. County	1	10c. C	ity, Town or Lo Baltin						10d. Inside City Limits 11 Yes 2 □ No
	Be-f	Director				- Dalti				10- 4	Divinos - 4 1465 - 4	21
	with t	ă	10e. Street and Number 4501 Anntana	A 77 0 m 1 1 0			10f. Zip Code	206		109.1	Citizen of What	
	ms 23	Funeral	11. Marital Status	12. Was Dec	edent Ever in U	J.S. 13.	Was Decedent of H	206 ispanic Ori	gin? (Specify Ye	s or No-		merican Indian,
39	filed within 72 hours after death with the Maryland Hyglene. titler then "neturel", or items 23a or 28e-f show inti, the Medical Examinar must be notified at		1 ☐ Never Married 2 X Mai 3 ☐ Widowed 4 ☐ Divorce	If Yes. G	2⊠No ve		f Yes, specify Cuba 1 ☐ Yes 2🌠 No	Specify:	n, Puerto Hican, e	etc.)	Specify: W	hite, etc. 7hite
21215-0036	72 hor	Completed by	15. Oecede	nt's Education est grade completed)		16a. Oeceo	dent's Usual Occup	ation	t of working	16b.	Kind of Busine	ss/Industry
21	ithin 79.	mple	Elementary/Secondary (0-12)	College (	1-4or 5+)	life.	DO NOT use retired	1)	. o. woming			
12	iled w Hygier Iher ti nt, In		17. Father's Name (First, Middle	(ast)		l h	omekeepr	18 Mothe	er's Name (First,	Middle Maid		home
and	d be f	o Be	Louis M. Reha						tilda Ma			
Maryland	shoul nd Me mari	ဥ	19a. Informant's Name/Relation	ship (Type, Print)		19b. Mailir	ng Address (Street			-		a, Zip Code)
	alth a alth a 27 ls		Gregory Amrhei	.n/son		4501	Anntana .	Avenu	e Baltin	ore, N	MD 2120	)6
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Importent: If item 27 is marked other then "neturel; or items 23s or 28e-f show any injury or other treumatic event, the Modical Examinet must be notified at Once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☒ Donation 5 ☐ Other (			Place of Dispo cemetery, crer	sition (Name of matory or other place	ce)	Date	20c.	Location - City	or Town, State
Balti	permit. Departmit. Importe any inju		21 Stynburg of Funeral Service Ronal of	S. Wade	Directo	2	Name and Addres tate Ana altimore	ss of Facilit COMY MD	Board 65 21201	5 W. I	Baltimo	re Street
Г			23a. Part1. Enter the disease, of shock, or heart failure. Lis	or complications that	caused the dea				cardiac or respira	atory arrest,		Approximate Interval Between
	Physician	8 4	Immediate Cause (Final disease or condition	Non	11	oll lun	4 (01)(4	00				Onset and Death
	/Medical Examiner		resulting in death)	a	(or as a conse		/					7 17 67 19
	Examiner	L	Sequentially list conditions,	b. — Due to	(or as a conse	auanan afti						
	ted nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	A Due to	(OI as a COIISE	querice or).						
,	execunand nand ial-tra	Exar	that initiated events resulting in death) Last	c Due to	(or as a conse	quence of):						
8760,	cate be executed physician and the burial-transit	dlcal		d								
9			IF FEMALE:									
Вох	death certifi e attending id for use as	Physiclan/Me	23b. Was decedent pregnant in the past 12 months?	1□Live	itcome of pregn birth 2 □Fet	al death 3	Ectopic pregnancy	,			23d. Date of o	delivery Day Year
0.	the a	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4∐Preg 9□Unkr	nant at time of lown	death 5	Other (specify)					,
<b>₽</b>	requires that the death een signed by the atter hould be detached for a	/Ph	Part II. Other significant condit	ions contributing to	leath but not re	sulting in the u	nderlying cause giv	en in Part I.	. 236	e. Did tobacc	o use contribute	to the cause of death?
Vital Records,	es ign	d by								1 🗌 Yes	2□No 3₫	Frobably 4 DUnknown
CO	> 0 0	Completed							248	. Was an	24b. Were	autopsy findings available
Re	9 4 9	Juo								autopsy performed? Yes 2	death	
ita	siclen: Th certificate rector, pag	Be C	25. Was case referred to medic examiner?	al				26. Place	of Death (Check		10 101	00 20,10
of V	S - E	70	1 ☐ Yes 2 Z No	Hospital: 1	Inpatient 2	ER/Outpatier		4 🗀 140	rsing Home 5[	Residence	6 □Other (S	pecify)
D C		0.01	27. Manner of Oeath  1 ☑ Natural 5 ☐ Pend	iiig	of Injury oth, Day Year)	28b. Time of Injury	Wor	y at k?		scribe how in	jury occurred	
isio	Attending r death. ector: After by the fune	icat	3 ☐ Suicide 6 ☐ Could		e of Injury - At h	nome farm etc	M 1 [	Yes 2 🗌		ation (Street	and Number or	Rural Route Number,
Division	l or At after o Direc	ertification	4 Homicide deter	mined 200. Flac	ling, etc. (Spec	ify)	eet, factory, office		City	or Town, Sta	ate)	Tidrai Flodie Natilber,
	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	dical C	29a. Certifier 1 Certify (Check only 2 Medica	ing Physicien: To the I Examiner: On the I and mar	e best of my kn casis of examin oner stated.	owledge, death ation and/or in	h occurred at the tin vestigation, in my o	ne, date an pinion, dea	d place, and due th occurred at the	to the cause time, date a	(s) and manner and place, and d	as stated. ue to the cause(s)
	To the To the comple	Me	29b. Signature and title of certifi	er er			29c. Licens	e number		29d. (	Date signed (Mo	onth, Day, Year)
			> Herenza	remmen /	NP		AT.	2438	8946E	7 No	14 9	2005
			30. Name and address of person	n who completed cau	se of death (Ite	m 23a) (Type,	Print) NIVEVSIKY	Park	kway b	al4moi	R MO	21218
	Sta Regist		31. Date filed (Month, Day, Yea, MAY 1 2 2	2005 Black	Registrar's Sign	ature	W .					

State of Maryland / Department of Health and Mental Hygiene

			Certificate of	Death	R	eg. No. 201	15 1606
Physician	1. Decedent's Name (First, Middle, Last)		-		2. Date of Deat Month	h Day Year	3. Time of Death
/Medical	Alfred A	lbert			May 5,	2005	9:10 AM
Examiner	4a Facility Name (If not institution, give s			4b. City, Town, or Lo	cation of Death	4c. County of De	ath
	Charles County			La Plata		Charle	
Funeral Director	219-42-3813	7. Age (In yrs. I	Months Dave		8. Date of Birth (Month, Day, Mar 18	, 1930 Ger	irthplace <i>(State or Foreigr</i> Country) 'many
p s	Usual Residence of Decedent  10a. State 10b. County	10c City	, Town or Location				10d. Inside City Limits
asho							1 € Yes 2 □ No
with the Market secretary	MD Charles  10e. Street and Number		Cobb Island  10f. Zip Code			0.000	
ter death with the Marylan items 23s or 28s-1 show iner must be recitied at Tuneral Director	18204 Piedmont D	rive		0625		0g. Citizen of What C	ountry?
urs af	3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U, Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	S. 13. Was Decedent of If Yes, specify Cub	oan, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - An Black, Wh Specify: W	
ygiena.  Ygiena.  Ner than "nature  It, the Medical E	15. Decedent's Educ (Specify only highest grade		16a. Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	pation during most of worki	ng	16b. Kind of Busines	s/Industry
withir than the Min	Elementary/Secondary (0-12)	College (1-4or 5+)	Electrician	•		Private	
B S S S			Dicciliciai	18. Mother's Name	/First Middle A		
should be fill and Mental H and marked out umatic ever	77 1				nine Alb	,	
and	19a. Informant's Name/Relationship (Type		19b. Mailing Address (Stree				Zip Code)
is 1 and 2 of Haalth item 27 i	Hannelore Albert		P.O. Box 15	8 Cobb Isl	and MD	20625	
pamit. Pages 1 Department of Hi important: if iten any injury or oth	20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ R  4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	ace of Disposition (Name of emetery, crematory or other pla rt Lincoln Cre			20c. Location - City o Brentwood	
mit.	21. Signature of Funeral Service License	ee	22. Name and Addre	ess of Facility For			
parm Depa impo any is	DV		1	lensburg Ro			
Physician	23a. Part1. Enter the disease, or complic shock, or heart failure. List only on	cations that caused the death e cause on each line.	. Do not enter the mode of dyi	ng, such as cardiac o	r respiratory arre	est,	Approximate Interval Between Onset and Death
/Medical Examiner	rosulting in doubly		as a consequence of):	CARCINO	MA PI	IROTIO	GWKS
aath certificate ba axecuted attanding physician and I for usa as the bunal-transit clan/Medical Examiner	Cause (Disease or injury that initiated events resulting in death) Last		as a consequence of):				
tha daath y tha attar sched for u	Dad II Other step Misses and Misses				not pided		
at the death c d by the attenc leteched for us Physician	Part II. Other significant conditiona conf		iting in the underlying cause gr	ven in Part I.			e to the cause of death Probably 4. Unknow
as that igned to be dat	114062760	sion			10,10	3 2010 001	TODADIY 12 OTKION
been s should	GASTROESO	PHAGGAL R	t FLO'S		24a. Was ar perform	ed?	Were autopsy findings available prior to completion of cause of death?
he law a has aga 2					1 □ Ye		1 □ Yes 2 No
ertificat ector, p	25. Was case referred to medical			26. Place of Death			72.00 22.00
hysicle his cert al direct	evaminer?	ospital: 1 ☐ Inpatient 2 ☐ E	ER/Outpatient 3□ DOA Ott	ner·		nce 6 Other (Spe	noifu)
Attending Physician: Ir death. Setor: After this certific by the funeral director, Iffication: To Be (	27. Manner of Death 1 ☑ Natural 5 ☐ Pending		28b. Time of 28c. Inju Wo			w injury occurred	suly)
tal or Attending P rs aftar death. al Director: After ti lad in by the funera Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)	me, farm, street, factory, office		8f. Location (Str. City or Town,	eet and Number or R State)	ural Route Number,
To the Hospital or Attending Physician: The is within 24 hours after death.  To the Funeral Director: After this certificate he complately filled in by the funeral director, page.  Medical Certification: To Be Com	29a. Certifier (Check only one) Certifying Physical Examination	cian: To the best of my know er: On the basis of examination and manner stated.	rledge, death occurred at the ti on and/or investigation, in my o	me, date and place, a opinion, death occurre	nd due to the ca d at the time, da	use(s) and manner a te and place, and du	s stated. e to the cause(s)
o the vithin To the compliance	29b. Signature and title of certifier		29c. Licens	se number	29	d. Date signed (Mon	th, Day, Year)
F > F 0	130		0	48116		MAN E	2000
^	30. Name and address of person who cor	noleted cause of death /Itam	23a) (Type Print)	48119		MAN 5	02
10	R.E.BRANSDO	1p 12070	olb line e	TN 576,	100 h	DIDONA	-MO
State Registrar	31. Date filed (Month, Day, Year) MAY 1 2 211	32. Rishstrar's Signatu	K Angelle				

1			1 - For State Registrar	State of Mar		artment rtificate			nd M	А	eg. No.?	05	16053
	Physic		1. Decedent's Name (First, Middle, Last) Stanley McNaul Be	11 Jr.						2. Date of Dea Month May	Dav	2005	3. Time of Death  8: 30A M
	/Medi Examir		4a. Facility Name (If not institution, give s. Chapel Hill Nursi	,		4b. city, T Rand		Location of	Death		4c. Count	y of Death timon	
	Funeral Director		5. Social Security Number 569-18-5370  Usual Residence of Decedent	7. Age (	(In yrs. last birthday) 86 Yrs.	If Under 1 Months	Year Days	Hours	4 Hrs. Min.	8. Date of Birth (Month, Day Dec • 9,	1918	9. Birthr Cour Mar	place (State or Foreign ntry) y Land
	Maryland a-f show	tor	10a. State 10b. County Maryland Baltimor		Oc. City, Town or Lo	cation	own					1	1 ☐ Yes 2 No
	or 28s	Funeral Directo	10e. Street and Number	_		10f. Zip 0	ode			1	0g. Citizen of	What Cour	ntry?
	ns 23a	erai	4511 Robosson Roa	d 2. Was Decedent Ev	er in U.S. 13.		1133		in? (Spe	cify Yes or No-	USA 14. Ba	ce - Americ	ean Indian
036	ours after d rel', or Iten Examenar	þ	1 Never Married 2 Married 3 XWidowed 4 Divorced	Armed Forces?  1 XYes 2 □ No If Yes, Give Year or Dates:	1941	fYes, specif 1 ☐ Yes 2		, Mexican, Specify:	Puèrto F	cify Yes or No- Rican, etc.)		ck, White,	etc.
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. I Health and Mental Hygiene. Item 27 is marked other then "naturel", or Items 23a or 28a-1 show other treumetic event, II is Maralfal Example intelliging at	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usual kind of work DO NOT use Nager	Occupa done di retired)	tion uring most o	of workin	ng	Food I		•
2 ام	tould be filed via the filed v	Be Co	17. Father's Name (First, Middle, Last)	<u> </u>				18. Mother's	s Name	(First, Middle, I			LLY
Maryland	should be and Menta marked umetic ev	ToE	Stanley McNaul Bel							a Snydei			
Mar	id 2 sho lth and 27 is mu treum		19a. Informant's Name/Relationship (Type Mary Elizabeth Bell Stee							Route Number			
altimore,	0 0		20a. Method of Disposition  1  Burial 2 Cremation 3 Re  4 Donation 5 Other (Specify)		20b. Place of Disponsion Cress  Metro Cress	sition (Name natory or oth	of er place	)	Da		20c. Location	- City or To	own, State
Baltir	permit. Pag Department Importent: I eny injury o once.		21. Signature of Funeral Service License Thomas Gregor	ə							and In	c. rvlar	Maryland and 21228
	Physician		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition	ations that caused the cause on each line.	e death. Do not ent	er the mode	of dying	such as ca	ardiac or	respiratory arm	est,	Lyzar	Approximate Interval Between Onset and Death
	/Medical Examiner	П	resulting in death)	Due to (or as a		CITO	1-11	- INFIGH	1/1	3(47)			7243
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a o	consequence of):								
8760,	tate be executed obysician and the burial-transit		resulting in death) Last	Due to (or as a o	consequence of):								
O. Box 68	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	c. If yes, outcome of 1 Live birth 2   4 Pregnant at tin 9 Unknown	Fetal death 3	Ectopic pred						ate of delive	ery Day Year
rds, P.	quires that t in signed by uld be detai	þ	Part II. Other significant conditions cont	A.	ot resulting in the ur	nderlying cau	se giver	in Part I.		23e. Did tob	_		e cause of death?
Records,	The law requir ate has been si page 2 should	Completed						<del></del>		24a. Was ar autops perform	ned?	prior to cor death?	psy findings available inpletion of cause of
Vita	Physicien: this certifica ral director, p	Be	25. Was case referred to medical examiner?	enital:					of Death	(Check only on			
o	Phys this ral dii	tion; To	27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day Y	2 ER/Outpatien  28b. Time of Injury		Other	4 Nurs	28	e 5 Reside			')
Division	ten feat tor: the	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (	- At home, farm, stre (Specify)			20.10		Bf. Location (Sti City or Town	eet and Numb , State)	er or Rura	l Route Number,
	To the Hospitel or At within 24 hours after or To the Funerel Directompletely filled in by	edical C	29a. Certifier (Check only one)  12 Certifying Physical Control (Check only one)	cian: To the best of refer. On the basis of each	camination and/or inv	occurred at restigation, in	the time	, date and p nion, death	place, ar occurre	nd due to the ca d at the time, da	use(s) and ma ite and place,	anner as st and due to	ated. the cause(s)
	To the l	Me	29b. Signature and title of certifier	MS		29c. 1	icense	18 (		29	od. Date signe	d (Month, I	Day, Year)
	4		30. Name and address of person who con	chase 11	4 Buchac	(h)	8	Dane	R	(13/47/Pm	in, M	1) 21	176
	Sta Registi		31. Date filed (Month, Day, Year)	32. Registrar's	Signature .	y A	arti	,			,		

			1 - For State Registrar	State of N		nd / Depa	artment of rtificate of	Health a	and Menta	-	ne	S lenst
			Decedent's Name (First, Middle, L.	ast)				Dodin		e of Death		3. Time of Death
	Physici /Media		JEAN P. BLACKWE						MA		Day Yes	- AM
	Examir	er	4a. Facility Name (If not institution, g.		r)		4b. City, Town,		of Death	1	4c. County of D	eath
	Funeral		UNION MEMORIAL  5. Social Security Number 6.		Age (In yrs.	last birthday)	BALTI If Under 1 Yea	r If Under	24 Hrs. 8. Dat	e of Birth onth, Day, Ye	9.	Birthplace (State or Foreign
	Director		214-50-7019	1□M 2XXF	57	Yrs.	Months Days	s Hours	Min. (Mo	nth, Day, Ye Y 29,1	947	Country) MD
	and		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	ty, Town or Lo	ocation					10d. Inside City Limits
	Mary -f sho	tor	MD			ALTIMOI						1 X Yes 2 □ No
	th the or 28e	Funeral Director	10e. Street and Number			ALITIO	10f. Zip Code			10g.	Citizen of What	Country?
	ath w	ral	1515 CLIFTON AV					1217			US	
	items items	une	11. Marital Status  1 ☐ Never Married 2 ☒ Married	12. Was Deceden Armed Forces 1 \( \text{Yes} \) 2 \( \text{Y}	5?	.S.   13.	Was Decedent of If Yes, specify Cu	Hispanic Ori ban, Mexicar	igin? (Specify Ye n, Puerto Rican, e	s or No- etc.)	14. Race - A Black, W	merican Indian, /hite, etc.
920	72 hours after death with the Maryland natural; or Items 23e or 28e-f show Jical Evanitati Leundillad al	by	3 □ Widowed 4 □ Divorced	If Yes, Give Year or Dates	_		1 ☐ Yes 2 🎇 No	Specify:			Specify:	BLACK
5-0	hin 72 hours after death with the Marylan B. Medical Exaction to ast to notified at	Completed	15. Decedent's ( (Specify only highest g			16a. Dece	dent's Usual Occu kind of work done DO NOT use retir	upation e during mos	t of working	16b	. Kind of Busine	
121	E E S Ki	dmo	Elementary/Secondary (0-12)	College (1-4o	r 5+)		DO NOT use retir JRSE	ed)		77	ENGON M	IDATNA HOME
d 2	Hyginather Ant, I	Be Co	17. Father's Name (First, Middle, Las	it)		I IN	JKSE	18. Mothe	er's Name (First,			URSING HOME
/lar	should be nd Mental s marked c umatic ava	To B	EDWARD STEWART					MAR	Y BLACK	VELL		
Maryland 21215-0036	and and is m		19a. Informant's Name/Relationship MARY BLACKWELL/				ARGYLE				•	
	Health Health Itam 27 other tra		20a. Method of Disposition	HOTHER	20b. F	Place of Dispo	sition (Name of		DALITY		MARYLANI Location - City	
Baltimore,			1 XBurial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		9	•	natory`or other pl	, I	5-17-20			E, MARYLAND
ati	ertra inju		21. Signature of Funeral Service Lice		, 111		Name and Addr		A Comment of the Comm			ONS F.H., INC.
_	Dep Imp		James C	1. Mor	COY		701-31 I		S ST. B	ALTIMO		YLAND 21217
8	a =		23a. Paty. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final	y one cause on each	ed the deat line.	n. Do not ent	er the mode of dy	ring, such as	cardiac or respira	atory arrest,		Approximate Interval Between Onset and Death
	Pnysician /Medical	ĺ	disease or condition resulting in death)	a. COCON Due to (or a	ARY A	ARTER	y DISEA	SE				OVER 10 yrs
H	Examiner		Sequentially list conditions	b. Pulm	ONIAR	HYP	EXTENSI	οN				NEW TO UKS
1	pe tis	lner	Sequentially list conditions, any leading to the red late cause. Enter Underlying Cause, (Disease or injury)	Dina to (or a	s a consac	ence of)						
V	be executed sician and burial-transit	Examln	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or a		uence of):						OVER 10 YRS
<u></u>	# 5 9	cal		d								
k 68	that the death certifica ed by the attending ph detached for use as th	Med	IF FEMALE:									
Вох	attend for us	clan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1☐Live birth 4☐Pregnant	2 Feta	I death 3	Ectopic pregnand Other (specify)	Су			23d. Date of o Month	delivery Day Year
Ó.	t the d by the ached	Physician/M	1 Yes 2 No 9 Unknown	9□ Unknown			Journal (Specify)					
s, D	Se us	<b>by</b> Р	Part II. Other significant conditions	contributing to death	but not res	ulting in the u	nderlying cause g	iven in Part I.	. 236	e. Did tobacc	. /	to the cause of death?
ord	w requir been si should l	eted								1 Tes		Probably 4 Unknown
Records,	The law cate has b page 2 s	Completed							24a	<ol> <li>Was an autopsy performed'</li> </ol>	prior t	autopsy findings available o completion of cause of ?
	10 -	O	25. Was case referred to medical					26 Place	of Death Check	Yes 2	No 1□Y	es 2 No
of <	tanding Physician: leath. tor: After this certific the funeral director,	To B	examiner? 1 🗆 Yes 2	Hospital: 1 Impat	tient 2 🗆	ER/Outpatien	t 3 DOA	hor	rsing Home 5		6 □Other (S)	pecify)
		lon:	27. Manner of Death  1 Natural 5 ☐ Pending	28a. Date of Inj (Month, D	jury ay Year)	28b. Time of Injury	Wo	ork?		scribe how in	njury occurred	
Division	i or Attanding after death. Diractor: After I in by the fune	flcat	2 Accident investigativ 3 Suicide 6 Could not determine	De Diago of Ir	njury - At ho	ome, farm, str	M 1 [	]Yes 2 □ i		ation (Street	and Number or	Rural Route Number,
	s after s after al Dira ed in b	Certification:	4 Homicide	building, e	etc. (Specif	y)			City	or Town, St	ate)	
	To the Hospital or At within 24 hours after or To the Funaral Dirac completely filled in by	edical (	29a. Certifier (Check only one) Certifying P	hysician: To the bes	of examina	wledge, death tion and/or in	occurred at the t vestigation, in my	ime, date and opinion, deat	d place, and due th occurred at the	to the cause time, date a	(s) and manner and place, and d	as stated. ue to the cause(s)
	To the I	Med	29b. Signature and little of certifier	and manner s				se number			Date signed (Mo	
)			Nalla Malla	Lup			AT	2439	3946	11	ALI II	2005
	4		30. Name and address of person who		death (Item	1 23a) (Type,				,,,,,,,	1	Car Caral
	Sta	to	KINGERIU LUALLAC 31. Date filed (Month, Day, Year)		trar's Signa	ture	PARKL	UAY :	BALTIMOX	E, MD	21216	5
	Registr			2005	wa.	K. A	mel	1				

			For State Registrer	State of Ma	aryland .		artment of rtificate of	Health a	and M	ental Hyg		2005	16055
	Physici		1. Decedent's Name (First, Middle, La							2. Date of Dea Month			3. Time of Death
	/Medic		Steven E			f				05	09		0245 M
	Examir	er	4a. Facility Name (If not institution, give				4b. City, Town, Baltin		of Death		4c.	County of Dea	th
			Union Memoria 5. Social Security Number 6.5		a 1 je (In yrs. last	t hirthday)	If Under 1 Yea		24 Hrs.	8 Date of Birt	h	Q Bir	tholaca (State or Foreign
	Funeral Director			<b>№</b> M 2□ F	45	Yrs.	Months Days		Min.	8. Date of Birtl (Month, Day March	14,	1960 M	thplace (State or Foreign ountry) aryland
	yland		10a. State 10b. County		10c. City, T								10d. Inside City Limits
	B Mar	ctor	MD Balti	more		Ess	ex						1 ☐ Yes 2 X No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "neturel", or Items 23e or 28e-1 show say injury or other treumatic event, it is Medical Exart and intal to indiffic a once.	Funerai Director	10e. Street and Number 15 Haley Road				10f. Zip Code 212	21			10g. Citi USZ	izen of What Co	ountry?
	deati	nera	11. Marital Status	12. Was Decedent Armed Forces?		13.	Was Decedent of If Yes, specify Cu	Hispanic Ori	igin? (Spe	cify Yes or No-		14. Race - Ame	
36	or Ite	y Fu	1 Never Married 3 Married	1 ☐ Yes 2 ☑ If Yes, Give		}	1 ☐ Yes 2√∑ No			ticari, etc.)		Black, Whit	·
Ö	hours turel',	ed by	3 Widowed 4 Divorced	Year or Dates:									
5	in 72	ojete	15. Decedent's E (Specify only highest gr	ade completed)		(Givo	dent's Usual Occi kind of work don DO NOT use retir	a during mos	t of workir	ng		nd of Business	,
212	d with jiene. r thar	Completed	Elementary/Secondary (0-12)  12th	College (1-4or 5	5+)		iver	,			Snc	ppers	Warehouse
ğ	e filec al Hyg othe vent,	Be C	17. Father's Name (First, Middle, Last	)				18. Mothe	er's Name	(First, Middle,	Maiden	Sumame)	
ylaı	Menta Menta Briked	Tof	Eugene T. Bi	ggerstaf	f			MAr	ie D	llls			
Maryland 21215-0036	id 2 sho Ith and 27 Is m		19a. Informant's Name/Relationship ( Marie Biggerst				ng Address <i>(Str</i> ee : Marte						
	ges 1 ar t of Hea If item 3 or other		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □		20b. Place	e of Dispo	sition (Name of matory or other pl ringsBa	ace)	D:	ate		cation - City or	
Baltimore,	nit. Pagartmenl ortent: injury e		<ul><li>4 □ Donation 5 □ Other (Special</li><li>21. Signature of Funeral Service Lice</li></ul>	(y)	4.0								meofEssex
B	permi Depa tmpo eny is		+ R. Terry	Conn	elly							MD 2	
П		2	23a. Part1. Enter the disease, or conshock, or heart failure.	plications that caused one cause on each li	the death to	To not ent	er the mode of dy	ring, such as	cardiac or	r respiratory arr	rest,	,	Approximate Interval Between Onset and Death
	Physician (Madical		Immediate Cause (Final disease or condition resulting in death)	a. Aw	372	V.	Lacture	SIAC	\	SHA 24	er.	on	2 Hocas
	/Medical Examiner		1	Due to (or as	a consequen	ce of):							
		e	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequen	ce of):							
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Ó	leath certifica attending ph I for use as t	Physician/Med	IF FEMALE:	OZa Huga automa	-4								
Вох	attend for us	ian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal dea	ath 3□	Ectopic pregnan	су			2	23d. Date of del Month	ivery Day Year
P.O.	at the de by the a tached i	ysic	1 Yes 2 No 9 Unknown	9□ Unknown	time of death	1 5	Other (specify)						
	law requires that the as been signed by th 2 should be detache	by PI	Part II. Other significant conditions	ontributing to death b	ut not resultin	ig in the ur	nderlying cause g	iven in Part I.		23e. Did to	bacco u	se contribute to	the cause of death?
Records,	w require been sig should b	ed b	HORRIC STE	212504		DIA	237327			1 🗆 Y	es 2[	□No 3□Pr	obably 4 Unknown
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of	Physic this c	L L	1 Yes 2 No	Hospital: 1 Inpatie		Outpatien	t 3 DOA	ther: 4 🗆 Nu				Other (Spec	cify)
no	ding F h. After funer	lion	27. Manner of Death  1 Natural 5 Pending 2 Accident investigatio	28a. Date of Inju (Month, Day	y Year) 28t	b. Time of Injury	28c. Inju Wo M 1 [	uryat ork? ]Yes 2∐I		8d. Describe ho	ow injury	occurred	
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á	s after el Dire	Certification:	4  Homicide	building, etc	c. (Specify)		, ,,		ı	City or Town	n, State)		
	To the Hospitel or Attending Physician: within 24 hours after deals. To the Funerel Director: After this certificacompletely filled in by the funeral director,	Medical	29a. Certifier (Check only one)  Certifying Photographic Certifying Photograph	nysicien: To the best of miner: On the basis of and manner sta	examination	dge, death and/or inv	occurred at the frestigation, in my	ime, date an opinion, dea	d place, a th occurre	nd due to the co	ause(s) late and	and manner as place, and due	stated. to the cause(s)
	To th within To th comp	M	29b. Signature and title of certain	1				se number		2	9d. Date	e signed (Monti	n, Day, Year)
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	5		A CHERRY	ATL BOY	5025		3449 6	Jiller	is bi	e #3	<i>م</i> خ	BALTO	21229
	Sta Registr	-	31. Date filed (Month, Pay, Year) 20	105 Hegistra	ar's Signature	Los	de la						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death **Physician** Year 2:30p May 3, 2005 Leven A. Brvan /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Baltimore N/A Joseph Richey Hospice, Inc. If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 🖫 M 2 🗆 F Months Days Hours Yrs. Md Director 217-40-4858 63 Oct 3, 1941 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner: wat be notified at 1 Yes 2 □ No Randallstown Director Md. Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 Chris Court 21244 U.S.A. Itams 23a Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 5 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: ģ Specify. **Black** 3 ☐ Widowed 4 ☐ Divorced "natural", Completed other traumatic event, the Mudical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 12 should be filed within 7 h and Mental Hygiene.
7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Hospital Surgical Technician 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Roberta Booze Leven Bryan ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health itam 27 7 Chris Court Randallstown, Md. 21244 Irene Warren Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of I-Important: If its any injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 05/03/05 Lansdowne, Md. ` 4 ☐ Donation 5 ☐ Other (Specify) Mt. Zion Cemetery 21. Signature of Funeral Service Licens 22. Name and Address of Facility Estep Brothers Funeral Service 1300 Eutaw Place Baltimore, Maryland 21217 23a. Part1. Enter the disease, or complications that caused the eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Hapato cellular **Physician** 1405 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of). Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-transil attending physician and Due to (or as a consequence of): Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) P.0. 1 Yes 21KINO 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? Comple 24a. Was an autopsy performe The 2 🔀 No 1 Tes 242 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 DOther (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 28b. Time of Certification: After Hospital or Attanding 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No investigation hours after death. 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral D 29a. Certifier 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Madicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0002270 aus, sm) Khan 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 82) Lindan Bre. Bello and 21201 TANES, MID 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 1 2 2005 Registrar

BRYAN expired 5,

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Date of Death BURKE POVIE 10:31AM Physician 08 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner AOSPITAL MANRE DE RFORD MEMORIAL Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. **Funeral** 1 ☐ M 2 🔀 F Yre Alabama Director 258-07-0460 1919 Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits World 10b. County the Medical Examiner must be notified at 1 ☐ Yes 2 No **Funeral Director** Iowa Scott or items 23a or 28a-f Bettendorf 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 4480 Stone Haven Drive 52722 USA death v 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: þ 3X Widowed 4 ☐ Divorced White Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry it Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 10 Inspector Textile other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental h Bagley Rody Matthews 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if itam 27 l 4480 Stone Haven Drive, Bettendorf, IA 52722 Mary B. MacKenna / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State ö permit. Page Department of Important: If any injury or once. Lakeview Memory Grdns 5-13-05 Phenix City, Alabama 4 Dogatio Other (Specify) 21. Signa <sup>22</sup> Name and Address of Facility Home, P.A. # I Service I censee 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Fali1. Enler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. MYO CARDUL Immediate Cause (Final disease or condition resulting in death) Physician /Medical **Examiner** CORDNARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed the burial-transit Box 68760, ERLIPIDEMLA Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year jo Month Day in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an autopsy Yes the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Almatient Other: 1 ☐ Yes 2 No 2 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 27. Manner of Death Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 🗌 Yes 2 □ No death. after death Director: / I in by the f 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide within 24 hours area.

To the Funeral Directory of the Funeral Directory of the Funeral Directory filled in Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29c. License number **5** 80 36940 29d. Date signed (Month, Day, Year)
MAY 8 2005 Name and address of person who complet MRFORD MEMOBIAL ADSPITAL Registrar

			1 - For Stata Registrar	State of Mary		artment of Hea <i>rtificate of De</i>			ne 005	15058
			Decedent's Name (First, Middle,	Last)				2. Date of Death	_	3. Time of Death
	Physici /Medic		Catherine	Во	hlander		M	lay 06	Day Year 2005	8:35 A M
	Examin		4a. Facility Name (If not institution,	give street and number)		4b. City, Town, or Loc	cation of Death		4c. County of Dea	th
			Ivy Hall Nurs		a con loot blob day	Middle F		Data of Birth	Baltim	
Н	Funeral Director		5. Social Security Number 134-09-3328	6. Sex 7. Age (In	n yrs. last birthday) Yrs.		lours Min.	B. Date of Birth (Month, Day, Y		thplace (State or Foreign ountry)
	ס		Usual Residence of Decedent				) پ	TTA 200	1914   Ma	ryland
	anylar show	_	10a. State 10b. County	10	c. City, Town or Lo	ocation				10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	the M	Director	Maryland Balt  10e. Street and Number	imore	Midd1	e River		100	. Citizen of What Co	
	Sa or	늅	1300 Windlass	Drive		21220			U.S.A.	ountry :
	death	Funeral	11. Marital Status	12. Was Decedent Ever Armed Forces?	r in U.S. 13.	Was Decedent of Hispar	nic Origin? (Spec	ity Yes or No-	14. Race - Ame	
9	after or Ite		1 Never Married 2 Marrie			If Yes, specify Cuban, M  1 ☐ Yes 2 ☑ No Si	pecify:	can, etc.)	Black, Whit	e, etc.
21215-0036	filed within 72 hours after death with the Maryland Hygiene. yther than "natural", or Items 23a or 28a-f show yet. It a Medical Examiner must be notified at	Completed by	3√ Widowed 4 □ Divorced	Year or Dates:				100	W	Thite
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pu	al Hyg	BeC	17. Father's Name (First, Middle, L.	•		18.	Mother's Name (	First, Middle, Ma	iden Sumame)	
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Mar	d 2 sh th and 7 ts m traum		19a. Informant's Name/Relationshi			ng Address <i>(Street and i</i> Platium Ave				
آو آ	Heali Heali tem 2		20a. Method of Disposition		20b. Place of Dispo	osition /Name of	Da		c. Location - City or	
D E	Pages ent of nt: If i		1 □XBurial 2 □ Cremation 3 '4 □ Donation 5 □ Other (Spe		•	matory or other place) Valley Cem.	. 05/10	/2005 F	enton NY	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or liems 23a or 28a-f show any injury or other traumatic event. It a Madical Examinat must be notified at ance.		21. Signature of Funeral Service L			2. Name and Address of Charles S	Facility			
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of Vital Records, P.O. Box 6	or Attending Physician: The law requires that the death certificate be executed the fuller death.  Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit in the contract of the	To Be Completed by Physician/Me	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent premant in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significent condition  25. Was case referred to edical examiner? 1   Yes 2   No   27. Manne   Death   1   atural   5   Pending	c. De MEN  Due to (or as a co  d. Hyporital:  1   Inpatient  28a. Date of Injury (Month, Day Ye)	onsequence of):  HYRO  oregnancy  JF-etal death of the of death of the of death of the office of the offic	Cther (specify)   Cother (spec	Place of Death ( Place of Death ( Versing Home 28	23e. Did tobac  1  Yes  24a. Was an autopsy performe 1  Yes 2  Check only one) 3  5  Residence d. Describe how	Month  coo use contribute to 2 No 3 Pr  24b. Were au prior to death? 1 Yes  de 6 Other (Specinjury occurred	Day Year  the cause of death?  obably 4 Thinknown  attopsy findings available completion of cause of 2 No  city)
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of Vital Records, P.O. Box 6	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit or provided to the completely filled in by the funeral director.	edical Certification; To Be Completed by Physician/Me	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infitiated events resulting in death) Last  IF FEMALE: 23b. Was decedent premant in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significent condition  25. Was case referred to edical examiner? 1   Yes 2   No 27. Manne   Death 2   Accident   Investigation   No 1   No 27. Manne   Death 2   Accident   Investigation   No 27. Manne   Death 2   Accident   Investigation   No 27. Manne   Death 2   Accident   Investigation   No 28. Certifier (Check only one)	C. Due to (or as a control of particular of	onsequence of):  HYRO  oregnancy  JF-etal death 3 [ e of death 5 [ ot resulting in the understand of the content of the conten	26.  26.  27 29c. License nur.	Place of Ceath ( Place of Ceath ( No 28)  2 No 28  late and place, an in, death occurred imber	23e. Did tobace  1  Yes  24a. Was an autopsy performe 1  Yes  2  Check only one)  5  Residence d. Describe how  f. Location (Street City or Town, Street Cit	Month  20 Use contribute to 2 Use a signed (Month)  24b. Were au prior to death? 1 Uses  26 Other (Specinjury occurred)  27 And Number or Rustate)  28 and place, and due	othe cause of death? obably 4 Dinknown utopsy findings available completion of cause of 2 Dinknown city)  ural Route Number, estated. to the cause(s)
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			State of Maryland / State of Maryland / State of Maryland / Registrer	Depa	rtment of H	ealth a Seath	and Mei	ntal Hyg	iene eg. No.	105	16	059
			Decedent's Name (First, Middle, Last)				2.	Date of Dea	th		3. Time	of Death
	Physici /Medio		Carol Ann Brockey				Ma	Month By 6,	Day 2005	Year	4:01	Р
	Examir		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location o	of Death	,	4c. Cour	nty of Death		
0			Carroll Hospital Center		Westmins				Carro			
3	Funeral Director		5. Social Security Number  216-74-3682  6. Sex 1 □ M 2 ☑ F  7. Age (In yrs. last b	Yrs.	Months Days	If Under a	Min.	Date of Birth (Month, Day ${ m u1y}$ 8,	. Year)	Coul	place (State ntry) Land	e or Foreign
1	and and		Usual Residence of Decedent           10a. State         10b. County         10c. City, To	own or Loc	ation						10d. Inside	City Limits
	Marylan f ehow	ō	Maryland Baltimore C	Caton	sville						1 🗆 Ye	es 2 No
	the rott	Director	10e. Street and Number	04001	10f. Zip Code			1	0g. Citizen o	of What Cou	ntry?	
	h with		413 Bathurst Road		21228	8			U.S.	Α.		
	deat mms	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. V	Vas Decedent of His Yes, specify Cubar	spanic Orig	gin? (Specify	Yes or No-		lace - Americ		
21215-0036	be filed within 72 hours after death with the Maryland stal Hygiene. So other than "naturel", or Itams 23e or 28e-1 ehow event, the Medical Examinar must be rigitified at	by	1 ☐ Never Married 2 ☒ Married 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		☐ Yes 21 No	Specify:	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	, 5.0.,	Spec			
2-0	72 ho natur	Completed	15. Decedent's Education 16. (Specify only highest grade completed)	6a. Deced	ent's Usual Occupa kind of work done d	ition	t of warking		16b. Kind of	Business/In	dustry	
2	ithin nan Mer	nple	Elementary/Secondary (0-12) College (1-4or 5+)	life. D	OO NOT use retired)	)						
	flygier flygier her ti		17. Father's Name (First, Middle, Last)		Dietitia		da Nama /F	inst Adiabath	State Maiden Sum	Gove	rnmen	t
Maryland	B a b	Be	James E. Martin				,	McMah		ате)		
<u> </u>	s 1 and 2 should f Health and Men item 27 is marke other treumetic	70		9h Mailin	g Address (Street a					wn State Zir	Code)	<del> </del>
<b>≥</b>		8 1			Sathurst I				e, MD		, 0000)	
ē,	Health Health tem 27 I				sition (Name of patory or other place		Date		20c. Location		own, State	
9	ages ent of nt: If i		Tabular 2 Ciernation 3 Hemovaritom State		atory or other place emorial P		5-12-2	005	Cumbeı	rland	Mars	71 and
Baltimore,	permit. Pages 1 an Department of Heal Importent: If item 2 any injury or other once.		21. Signature of Euneral Service Licensee	22.	Name and Address	s of Facilit	v					Tand
	E02 6 0		23a. Part1. Enter the disease, or complications that caused the death. Do		30 Edmond					MD 21:	228 Approxim	anto
	Pnysician		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition  Acute Subarachi Artery Aneurysii	noid						ebral	Interval B Onset an	etween
7	/Medical Examiner		resulting in death)  Due to (or as a consequence									
	sit ad	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	se ut).								
	icate be executed physician and s the burial-transit	xar	resulting in death) Last  C. Due to (or as a consequence	ce of):								
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687	ificate g phy as the	edic	0.									
Box	leath certific attending p I for use as	M/u	IF FEMALE: 23b. Was decedent pregnant 1	ath 3□	Ectopic pregnancy				23d. E	Date of delive	эгу	
P.O. B	res that the deat igned by the atti be detached for	Physician/Me	in the past 12 months?  1 Yes 2 No 9 Unknown  1 Unknown		Other (specify)					Month	Day	Year
	s that ned b e deta	by Pł	Part II. Other significant conditions contributing to death but not resulting	g in the un	derlying cause give	n in Part I.		23e. Did tol	oacco use co	intribute to th	ne cause o	f death?
rds	w require: been sig should b							1 □ Ye	es 2□No	3 🗌 Prob	ably 4	Unknown
Vital Records,	has beinge 2 sho	ompieted						24a. Was a autops	v	o. Were auto prior to co death?	psy finding mpletion of	s available cause of
a	hysician: The iz his certificate ha I director, page 2	e Co	25. Was case referred to medical		-	00 Plans	-4 D45 (C	1 Yes	2□No	1 X Yes	2 🗆 No	
Ξ	sicla s cert	o B	examiner?	Outpatient	3 DOA Othe	F		heck only on	ence 6 🗆 C	thor (Special	(r)	
o	ding Phy h. After this funeral c	-	27. Manner of Death 28a. Date of Injury 28b.	o. Time of	28c. Injury	at			w injury occ		y)	
ion	uttending death. ctor: Aft y the fun	atio	1 Natural 5 Pending (Month, Day Year) 2 Accident investigation	Injury	Work M 1 □ Y	es 2□1	No					
Division	or Atte after de Directo	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)	, farm, stre	eet, factory, office		28f.	Location (St City or Town	reet and Nur n, State)	nber or Rura	vi Route Nu	ımber,
_	To the Hospitel or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attending is completely filled in by the funeral director, page 2 should be detached for use as	edical C	29a. Certifier  (Check only only)  1 Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination a	dge, death and/or inv	occurred at the time	e, date and inion, deat	d place, and th occurred a	due to the ca	ause(s) and rate and place	nanner as s e, and due to	tated.	e(s)
	thin 2 thin 2 tha mplel	Med	one) and manner stated.  29b. Signature and title of certifier		29c. License				9d. Date sign			
	F 3 F 8		I him him, mid			CME		į		·	,,	
				a) (Tuna F	Print)			Ma	ay 7,	2005		201
			30. Name and address of person who completed cause of death (Item 23a	_/ (13PB, F	111 Penr	n Str	eet I	Baltimo	ore, M	arylar	nd 21	201
	Sta	ate	31. Date filed (Month, Day, Year) 32. Sojistrar's Signature	17.4								
	Regist	rar	MAY 1 2 2005	An	aske							

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** William Cleveland Brown 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner If Under 17 ear If Under 24 Hrs. 8. Date of Months Days Hours Min. (Month ME TU/IFK THORE 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 81 Months 1X M 2□ F Director 216-18-6525 1923 Maryland Sept. 14, Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b Counts 28a-f show other traumatic event, If a Medical Examiner nost be notified at Maryland 10e. Street and N 3130 Ry 1 ☐ Yes 2 ☑ No Baltimore Lansdowne 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 3130 Ryerson Circle 21227 USA Items 23a Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 ö 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Government d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other then "r Elementary/Secondary (0-12) College (1-4or 5+) Coast Guard Crane Operator 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Frederick Duval Brown Mary Mae Gurney 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Importent: If item 27 is in any injury or other traum once. 3130 Ryerson Circle, Lansdowne, MD 21227 Nadine Brown/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. Park | May 9, 2005 Glen Burnie, MD 21. Signature - Funeral Service License 22. Name and Address of Facility Sterling Ashton Schwab Funeral Home Inc. 736 Edmondson Ave., Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician SIFA /Medical **Examiner** Sequentially list conditions, if any, leading to irrimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a conseduence of Physician/Medical Examiner Due to (or as a consequence P.O. Box 68760, The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ funeral director, page 2 should be 1 Tes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed Yes 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To this 28b. Time of Injury 28c. Injury at Work? 27. Manner of Dath 28d. Describe how injury occurred Hospital or Attending 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Learning: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the the 29c. License number 29d. Date signed (Month. Day, Year) d title of certifier 29b. Signature a 0 30. Name and add entrol person with pleted cause of death (Item 23a) (Type, Print)

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State Registrar 32. Registrar's Signature

			For State Registrar	State of Marylan		Department of Hea Certificate of De			giene Reg. No	00	1 .7 0
			Decedent's Name (First, Middle, Last)	<b>A</b>		- 0		2. Date of Dea Month		6 U U O	3. Time of Death
	Physicia /Medic		FLOYD	BARNES	J	R.		May	7	2005	, 750 PM
	Examin	er	4a. Facility Name (If not institution, give s			4b. City, Town, or Lo	- 4		40	. County of Death	n
			5. Social Security Number 6. Sex	20. Theale		The second secon	If Under 24 Hrs.	8. Date of Birti	h -	9. Birth	nplace (State or Foreign
	Funeral Director			M 2□F 76		Yrs. Months Days	Hours Min.	(Month, Day 07 / 27 / 1	,, Year, 928		nplace (State or Foreign untry) iinia
	pu k		Usual Residence of Decedent  10a. State 10b. County	10c Cit	v Towr	or Location					10d. Inside City Limits
	Aanyla f sho	or		, , , , ,	-						1 X Yes 2 □ No
	r 28a-	Director	Maryland  10e. Street and Number		ват	timore 10f. Zip Code			10g. Ci	tizen of What Co	untry?
	th with		2652 West Layfaye	tte Avenue		21216			U	.S.A.	
	tams er na	Funerai	77.17.01.00.01.01.01	12. Was Decedent Ever in U. Armed Forces?		13. Was Decedent of Hisp If Yes, specify Cuban,	anic Origin? (Spe Mexican, Puerto I	cify Yes or No- Rican, etc.)		14. Race - Amer Black, White	
36	filed within 72 hours after death with the Maryland Hygiene. ther than "netural", or Itams 23a or 28a-f show that the Modical Examinational be notified at	by Fi	1 Never Married 2 Married 3 Widowed 4 Divorced	1 □ Wes 2 □ No 19 □ If Yes, Give Year or Dates: 19 □		1 ☐ Yes 2X No	Specify:			Specify: B1	ack
9	2 hou		15. Decedent's Educ	cation		Decedent's Usual Occupation	on		16b. k	(ind of Business/l	ndustry
215	thin 7	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)		(Give kind of work done dur life. DO NOT use retired)	ang most of workir	ig			
7	led will her the	Cor	17. Father's Name (First, Middle, Last)	2		Printer	8. Mother's Name	/First Middle		aphic Ar	ts
anc	d be find here	) Be	Floyd Barnes Sr.				Clarine W		walder	r Surname)	
Maryland 21215-0036	shoul nd Me mark	2	19a. Informant's Name/Relationship (Ty)	oe, Print)	19b	. Mailing Address (Street and			r, City	or Town, State, Z	lip Code)
	and 2 alth a 27 is		Rene' Jiggetts		_	08 Wicklow Ro	ad, Balt	imore,	Maı	yland :	21229
ore	of He of He If itan		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ R			Disposition (Name of y, crematory or other place)	!	ate		ocation - City or	
Baltimore,	tment tant: tant:		* 4 ☐ Donation 5 ☐ Other (Specify)	Gar	ris	on Forest Cem					
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene important: If item 27 is marked other than "netural", or Items 23a or 28a-f show any injury or other traumatic event, It a Mudical Exa. illustrated the notified at once.		21. Signature of Funeral Service Licen			22. Name and Address of 4611 Park Hg					• •
			23a. Part1. Enter the disease, or compli shock, or heart lailure. List only or	cations that caused the deat	h. Dor	not enter the mode ol dying,	such as cardiac o	r respiratory ar	rest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	Mefast	ah	c Prosto	te Ga	nar			Mently
	/Medical Examiner		Tooling in down,	Due to (or as a conseq	uence	of):					
		Jer	Sequentially list conditions, if any, leading to immediate	Due to (o. as a conseq	nei re	n).					
	cuted nd transif	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events								
60,	ilicate be executed g physician and as the burial-transif		resulting in death) Last	Due to (or as a conseq	uence	of):					
68760,	ficate physics the	edicai		l							
Вох	eath certif attending for use a		23b. was decedent pregnant	3c. If yes, outcome of pregna		3 □Ectopic pregnancy				23d. Date of deli	
о В	To the Hospital or Attending Physicien: The law requires that the death cert within 24 hours after death. To the Funarel Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use	by Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at time of d 9☐ Unknown		5 Other (specify)				Month	Day Year
P.O.	that ff	/ Ph	Part II. Other significant conditions cor	ntributing to death but not res	ulting ir	the underlying cause given	in Part I.	23e. Did to	bacco	use contribute to	the cause of death?
rds,	w requires to been signed should be		- Leukar	noid reall	ion	2º Metastel	Sc Pine	1 1 Y	es 2	No 3□Pro	obably 4 Unknown
000	aw re	piet	- Paraflej	ین و				24a. Was autop			topsy findings available completion of cause of
ď	The ate has page	Completed	- DM I					perfor 1 ☐ Yes	rmed?⁄	death?	2□ No
Vital Record	hysicien: The law nis certificate has I I director, page 2 s	Be	25. Was case referred to medical examiner?	lospital:		Other	26. Place of Death				
	Phys r this ral dir	1: To	1 Yes 2 No	28a. Date of Injury	_	ime of 28c. Injury at	4   Nursing Hor	ne 5 ☐ Resid 8d. Describe h		6 ☐ Other (Specing occurred	eify)
ion	nding ath. r: Afte e fune	atior	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	li	njury Work? M 1 ☐ Ye	s 2 No				
Division of	or Atte	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specification)	ome, fa	rm, street, factory, office	2	281. Location (S City or Ton			ral Route Number,
Ω	pital cours af		29a. Certifier 1 Certifying Phys	sician: To the best of my kno	ladaa	doub appured at the time	data and place of	and due to the	201100/0	and manner on	ntated
	To the Hospital or Attending Phwithin 24 hours after death. To the Funerel Director: After thi completely filled in by the funeral	edical	(Check only 2 Medical Examination)	ner: On the basis of examina and manner stated.	ition an	d/or investigation, in my opin	nion, death occurre	ed at the time,	date an	d place, and due	to the cause(s)
	To the within 2 To tha complet	Me	29b. Signature and title of certifier	Attena	l!	29c. License n	number		29d. Da	ate signed (Month	
)	, 1		Kuthy	w	M)	1 26	144		116	ダ リ,	2005
4	10	1	30. Name and address of person who co	empleted cause of death (Item My 1009 F	n 23a)	(Type, Print) 44 Rd. Se	lhimene	MS	21	228	
ì	Sta	ite	31. Date liled (Month, Day, Year)	32 Registrar's Signa	ature	Anadis		,			
	Registi	ar	MAY 1 % 20	UJ Colum 1	J.	The same of the sa					

Barnes, Floyd

		4	1- State Amend Item 1			partment of l 05 Eas ertificate of	lealth and M Death	lental Hygio	ene 05	decourse were	5062
	Physici	an	1. Decedent's Name (First, Middle, La Katherine Luci	le M. Carton		0 - 1		2. Date of Death Month	Day Y	ear	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, giv	a street and number)		Ab City Town	or Location of Death	May (	98 20 4c. County of		J3:3:1AM
	Examin	er	The Sphale	HOPKINS H	postal	BAH	1 MD2 res	1	4c. County of	Death	
2	Funeral		5. Social Security Number 6. S	ex 7. Age (In	yrs. last birthday	/) If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	(025)	9. Birthplace Country)	e (State or Foreign
v.	Director		333-10-0072	□M 2\\ F 9	1 Yrs.	Months Days	Hours Min.	June 4,		iscon	
	and w		Usual Residence of Decedent  10a. State 10b. County	100	c. City, Town or I	ocation				10d.	Inside City Limits
	Maryl f sho	to	MD		Baltim	ore					1 <b>X</b> Yes 2 □ No
	r 28e	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of Wh	at Country?	?
	th wit		4000 N. Charles	Street #1401			21218		USA		
	r dea	Funerai	11. Marital Status	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☑No	in U.S. 13	. Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		American I White, etc.	Indian,
36	hours after death with the Maryland urel', or Items 23c or 28e-1 show at Everifier must be notified at	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ZANo If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:		Specify:	whit	e
9	J within 72 hours after death with the Marylan titen. I then "naturel", or items 23s. or 28e-1 show The Medical Exeminer must be natified at		15. Decedent's E	ducation		edent's Usual Occup		. 16	3b. Kind of Busi	ness/Indust	try
215	l within 7 iene. r then "n Ins Medi	Completed	(Specify only highest gra	College (1-4or 5+)	life.	e kind of work done DO NOT use retire	during most of work d)	ing			
21	e filed wi it Hygien other th	Con	12	4	h	ousewife	40.14.1		own l		
Maryland 21215-0036	s 1 and 2 should be filled f Health and Mental Hyg item 27 Is marked othe other treumelic event,	Be	17. Father's Name (First, Middle, Last, Edmund Miles Mu]					e (First, Middle, Ma ne France			
ıry	2 should be and Mental Is marked o	유	19a. Informant's Name/Relationship (		19b. Mai	ling Address (Street					de)
	1 and 2 s Health ar tem 27 ls		Joseph Carton/son	•		GreenAcr			21286		
ore,	of Head		20a. Method of Disposition		0b. Place of Disg	oosition (Name of ematory or other pla	! (		c. Location - C	ity or Town,	State
Ē	Page ment ent: If ury o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 🕅 Donation 5 ☐ Other (Specif								
Baltimore,	permit. Pages Department of I Importent: If it eny injury or of		21. Signatur of Funeral Service Licer Ronald S.	Wade, Direc		2. Name and Addre tate Anat altimore,			Baltimo:	re Sti	reet
F			23a. Pant. Enter the disease, or com shock, or heart failure. List only	plications that caused the one cause on each line.	death. Do not e	nter the mode of dyir	ng, such as cardiac	or respiratory arres	it,	Int	proximate erval Between
	Pnysician	W I	Immediate cause (Final disease or condition resulting in death)	a Dreum	onia					14	set and Death
	/Medical Examiner		resulting in death)	Due to (or as a co	nsequence of):	a a				2.1	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \
		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a co	nsequence of):	COLE	ma				days
	cuted id ransit	Examine	Cause. Enter Underlying Cause (Disease or injury that initiated events	. Urev	lic.					7	dais
,0	ate be executed hysician and the burial-transii		resulting in death) Last	Due to (or as a co	nsequence of):						
8760,	cate be executed physician and the burial-transit	dicai		_ d							
9 x	death certifica e attending ph id for use as t	hysician/Me	IF FEMALE:	23c. If yes, outcome of pr	regnancy				23d. Date	of delivery	-
Вох	death atter	iciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time		☐ Ectopic pregnance ☐ Other (specify) _	У		Month		y Year
P.O.	that the ded by the detached	hysi	9 Unknown	9□ Unknown							
Ś	es gu	by P	Part II. Other significant conditions of	contributing to death but no	ot resulting in the	underlying cause giv	en in Part I.		cco use contrib		
ord	w requires been sign should be	ted	COLUESTIVE	TROOFF	+01	lure		1 🗆 Yes	2 No 3	Probably	4 □Unknown
of Vital Record	aw as b	Completed	UCUte Ke	suot H	anne			24a. Was an autopsy	pric	re autopsy or to comple ath?	findings available etion of cause of
alF								performe 1 Tes 2	No 1	Yes 2	] No
Σ		To Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:	2 🗀 ER/Outpatio	ent 3 DOA Ott	105	n <i>(Check only one)</i> me 5 ☐ Residen	ce 6 🗆 Other	(Spacifu)	
	g Physer this neral di		27. Manner of Death	28a. Date of Injury (Month, Day Ye	28b. Time	of 28c. Injur		28d. Describe how			
sior	Attending F ir death. ector: After by the funera	atio	1 Natural 5 Pending investigatio	n	ar) Injury		Yes 2 □ No				
Division	ol or Attend after death Director: / d in by the f	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		At home, farm, s pecify)	treet, factory, office		28f. Location (Stre City or Town,		or Rural Ro	oute Number,
	lospite t hours unerel	ledical C	29a. Certifier (Check only one)	nysician: To the best of my niner: On the basis of exa and manner stated.	y knowledge, dea mination and/or	ath occurred at the til investigation, in my c	me, date and place, pinion, death occurr	and due to the cau red at the time, date	se(s) and mann e and place, and	er as stated d due to the	d. cause(s)
	To the P within 24 To the F complete	Me	29b. Signature and title of certifier	112 1 1	/	29c. Licens	se number	290	l. Date signed (	Month, Day	; Year)
			Moderation	HLICON	ZM	DIRF	5-000	> 1	lay	8,2	005
•=			30. Name and address of person who		. 1					1	
				DWIN, JOHN	US HOPE	NS HOSPITA	r 600 No	ATH MONTE	STRAT	BAUTI	708E, 170 21289
100	Sta Registr		31. Date filed (Month, Day, Year) VIAY 1 2 20	2. Registrar's	St Ave	will s					

1 - For State Registrar

State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Dallillore, Marylarid 21213-0030		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland		
Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show	Fune Direc	
any injury or other traumatic event, the Medical Exertiner must be notified at	era :tc	

once. attending physician for use as the buria

Physician /Medical Examiner after death.

Dira tor: After this certific
in by the funeral director. within 24 hours a To the Funeral I the Hospital

of Vital Records, P.O. Box 68760,

Division

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 6,2005 21:30 pm may Rubie Carter /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospital of Baltimore Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 19 M 2 F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 427-09-7802 11-14-1912 Ms Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 X Yes 2 ☐ No Director Md N/A Balto 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5505 Lynview Avenue 21215 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: Black δ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Bethlehem Steel Elementary/Secondary (0-12) College (1-4or 5+) N/A Steel Cutter 4th grade 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Daisy Wilson Zeak Carter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vonderlia Holloway Granddaughter 5505 Lynview Avenue Balto, Md 21215 20a. Method of Disposition
1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 4 □ Donation 5 □ Other (Specify) Arbutus Memorial Pk 5-14-2005 Arbutus, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 4300 Wabash Avenue Balto, Md 21215 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CORON any
Due to (or as a consequence of): Lyears ourtery UROSEDSIS one month Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medlcal IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) \_ ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? "Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. dementia chaonie Renal insufficiency 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown thrombosis subdural 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 X No hematoma 1 Yes 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 X Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 0 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rospital of Baltimore ud, MD 32 Aegistrar's Signature Darla Sinai 31. Date filed (Month, Day, Year)
MAY 1 2 2005 State Registrar

DHMH 17 Rev 1/2001

Joyce Cox 05-3207 AKG

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

-3207			- For Unpend Item	State of Mar 23a,pt.II,2	ryland / 28a-	Depar	tment of H	ealth and	d Mental Hy -05 tas	/gien	2005	1606	5 4
	Dimeisi		Decedent's Name (First, Middle, La			00,0	outo o. z		2. Date of D	eath Da	av Year	3. Time of De	ath
	Physicia /Medic		Joyce			1			May 8	, 20	005	10:22	P <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, given Bon Secours Hospi	re s <i>treet and</i> nu <i>mber)</i> ital		ĺ	4b. City, Town, or Balti:	Location of De	eath	40	c. County of Dea ${ m N/A}$	th	
=	Funeral				(In yrs. last l	birthday)	If Under 1 Year	If Under 24 H		rth		thplace (State or Fountry)	oreign
50	Director		211 10 1512	1□ M 2  F	51	Yrs.	Months Days	Hours M	AUG 1	7, 1		aryland	
41	and		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	wn or Loc	ation					10d. Inside City L	 Limits
	Maryl -f sho	ţō	Maryland N/A				Bal	timore				1 Yes 2	□No
	or 288	Director	10e. Street and Number				10f. Zip Code			10g. C	itizen of What Co	ountry?	
	ath wi	ral	202 S. Bruce St				212				USA		
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or Items 23e or 28a-f show any injury or other treumatic event, the Medical Examinar must be notified at once.	by Funeral	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		If	as Decedent of Hi Yes, specify Cuba	ispanic Origin? n, Mexican, Pu Specify:	(Specify Yes or N lerto Rican, etc.)	0-	14. Race - Ame Black, Whit Specify:		
5-0	72 ho	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	16	Sa. Decede	ont's Usual Occupa ind of work done of O NOT use retired	ation during most of v	working	16b. I	Kind of Business	/Industry	
121	within ne. han "	mpi	Elementary/Secondary (0-12)	College (1-4or 5+	)				-		DT / A		
9	filed v Hygie other t	e Co	17. Father's Name (First, Middle, Last	t)		I/IG	ver Work		Name (First, Middle	e, Maide	N/A en Sumame)		
an	lid be fental rked c	To B	Leonard White					L	illian V	irgi	nia Smit	th	
Baltimore, Maryland 21215-0036	ind 2 shou alth and N 27 Is ma sr treuma		19a. Informant's Name/Relationship (Mildred Revis/S		1:		Address (Street a		Rural Route Number ad Balt		e, MD 2		
more	Pages 1 and of He not: If item		20a. Method of Disposition 1 ☐ Burial 2 【 Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Speci		ceme	tery, crem	tion (Name of atory or other place matory,		Date /10/05		Location - City or Saltimore		
alti	apertin aports ny inju		21. Signature of Funeral Service Lice	2000	A. Commission of the Commissio	22.	Name and Addres	ss of Facility	ty of MD, oad Balt	Tno	C .		
	205 # 9		Edward A. Gr	egorchik	he death D	2	99 Frede	rick Ro	oad Balt	imoi	re, MD 2	1228 Approximate	
			23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final	one cause on each line	·.			g, such as care	anac or respiratory	arrest,		Interval Betwee	
	Physician /Medical		disease or condition resulting in death)	a. Morphine Due to (or as a			TOH						-
	Examiner		Sequentially list conditions	b		,							
./	sit sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequenc	e of):							
V	xecute and II-trans	Examiner	that initiated events resulting in death) Last	c Due to (or as a	consequenc	ce of):							
8760,	icate be executed physician and the burial-transit	dicai	(	d									
9		w ·	IF FEMALE:	23c. If yes, outcome of	f pregnancy						23d. Date of de	livery	
Division of Vital Records, P.O. Box	0 0	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1□Live birth 2 4□Pregnant at ti 9□Unknown			Ectopic pregnancy Other (specify)				Month	Day Yea	kr
٦,	The law requires that the site has been signed by the bage 2 should be detache	by Pi	Part II. Other significent conditions		not resulting	g in the un-	derlying cause give	en in Part I.	23e. Did	tobacco	use contribute to	o the cause of deat	th?
ord	v require been sig should b	ted	Complications of	ALDS					_ 1□	Yes 2	2 12 No 3 □ P	robabiy 4 □Unk	inown
ecc	alawr hasbe e 2sh	Completed							_ 24a. Wa auto	s an opsy formed?	24b. Were a prior to death?	utopsy findings ava completion of caus	ailable se of
E H	vici <b>en</b> : The law certificate has l rector, page 2 s			1					1 Yes	2 🗆 N		2 □ No	
Zi.	ioi Gen	o Be	25. Was case referred to medical examiner?  1X Yes 2 No	Hospital:	t 2 [] EB/	Outpatient	3□ DOA Othe	or.	Death (Check only g Home 5 - Res		6 Other (See	vcifu)	
of	g Phye er this eral di	-	27. Manner of Death	28a. Date of Injury Found th, Day	288	. Time of	28c. Injun		28d. Describe			unk	
ion	auth. pr: After he funer	atio	1 Natural 5 Pending 2 Accident investigation	on 5-8-05		uhid <sup>y</sup> 40	<b>P</b> <sup>M</sup> 1□						
Divis	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the funer	Certification:	3 Suicide 6 ACould not i 4 Homicide determined		ry - At home, (Specify)	farm, stre	et, factory, office		28f. Location City or To		te) 107°S.	w <b>Addison</b>	'St.
	To the Hospital within 24 hours of To the Funerel I completely filled	edical		hysician: To the best of miner: On the basis of e and manner state	examination								
	J)	Σ	29b. Signature and title of certifier    Signature and title of certifier   Could be seen to be see	Hall, mis				ME			ate signed (Moni y 9, 200		
1	ok perg		30. Name and address of person who Pamela E. Su	completed cause of deadhalf, MD	ath (Item 23a	a) (Type, F	111 Penr	Stree	t Baltin	nore	, Maryla	ind 21201	
	Sta Registi		31. Date filed (Month, Day, Year)	32. Registrar			ant s						
DH	MH 17 Rev 1/2	001		1000	( ) JU	No.	R. S. College						

**ORIGINAL** 

			For State Registrar	State of M	aryland / [	Departmen Certificate				giene Reg. No.	05	16065
I	Physici /Medic		1. Decedent's Name (First, Midd		ah Cros	sby			2. Date of Dea Month	T Day	Year 05	3. Time of Death
	Examin Funeral	er	4a. Facility Name (If not institution SINA) Hosy 5. Social Security Number	oital of Br	THI MOR	E BA thday) If Under Months	1+1 m	ORE Inder 24 Hrs. ours Min.	8. Date of Birt (Month, Day Mar 24	4c. County		lace (State or Foreign
	Director		217-22-3193 Usual Residence of Decedent 10a. State 10b. County	,	87 10c. City, Tow	Yrs.	Dakina		Mar 24	, 1918		Od. Inside City Limits
	with the Ma a or 28a-f s be notified	Director	Md.  10e. Street and Number  2714 Classen Avenu	N/A		10f. Zip		ore  21215		10g. Citizen of	What Count U.S.A.	*
9000	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Items 23a or 28a-f show eny injury or other traumatic event, the Medical Examinal must be notified at once.	Completed by Funeral Director	11. Marital Status  1 Never Married 2 Mar  3 Widowed 4 Divorced	12. Was Decedent Armed Forces' rried 1  Yes 2 XI	No	1 ☐ Yes	2⊠ No Sp	nic Origin? (Sp exican, Puerto ecity:	ecify Yes or No- Rican, etc.)	14. Rad Bla Specif	ce - America ck, White, e y: Bl	
Maryland 21215-0036	ed within 72 h giene. er then "natu , the Medica	Complete		nt's Education est grade completed) College (1-4or		Decedent's Usua (Give kind of wor life, DO NOT us	k done during		ing	16b. Kind of B		/ Schools
ryland	nould be file d Mental Hy narked oth natic event	To Be (		ave Wilkes	106	Addition Address				beth Wilke	es	0-4-)
	s 1 and 2 sl of Health and item 27 Is r other traur		19a. Informant's Name/Relation Emily Staton 20a. Method of Disposition		20b. Place o	. Mailing Address 2914 Wes  f Disposition (Nan ry, crematory or or	st Coldspi	ring Lane-	Apt.D Balti	more, Md.	21212 - City or Tov	wn, State
Baltimore,	permit. Page Department of Important: If eny injury or once.		1 🔀 Burial 2 Cremation 4 Donation 5 Other (3	Specify)	·	22. Name an	norial Parl d Address of I tep Broth	Facility ers Funer	05/19/05 al Service F	PA	oncord,	NC.
	Physician /Medical		23a. Part1. Enter the diseaste, o shock, or heart feiliure. Lis Immediate Cause (Final disease or condition resulting in death)	aDue to (or as	ine.	not enter the mode	00 Eutaw e of dying, such	Place Ba	or respiratory ar	21217		Approximate Interval Between Onset and Death
8760,	icate be executed physician and s the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence	of): Lerot				داله	R	
P.O. Box 68	death certific e attending p ed for use as	by Physician/Media	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death	3 □Ectopic pro				1	te of deliver	ry Day Year
Ś	The law requires that the site has been signed by the bage 2 should be detache		Part II. Other significant condit	ions contributing to death	out not resulting in	n the underlying ca	ause given in l	Part I.	23e. Did to		tribute to the	e cause of death?
tal Reco	ician: The law r certificate has be rector, page 2 sh	e Completed	25. Was case referred to medical				26	Place of Doct	24a. Was a autopi perfor 1 Yes	med? 2. No	Were autop prior to com death? 1  Yes	psy findings available inpletion of cause of 25 No
Division of Vital Record	ttending Phys death. ctor: After this y the funeral di	Certification; To B	examiner? 1	Hospital: 1 Inpati	ay Year) 28b.		A Other: 4 8c. Injury at Work? 1 Yes	□ Nursing Ho	me 5 Resid 28d. Describe h 28f. Location (S City or Tow	ence 6 Oth	red	
۵	Hospital or A 4 hours after -uneral Directly filled in by		29a. Certifier 1 Cortifyi (Check only 2 Medica	ng Physician: To the best	of my knowledge	e, death occurred ad/or investigation.	at the time, da	ate and place,	and due to the d	ause(s) and ma	inner as sta	ated. the cause(s)
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	29b. Signature and title of certific	and manner s	tated.	1	. License num			29d. Date signe		
	7		30. Name and address of person	who completed cause of	death (Item 23a)	(Type, rint)	دمار	Ke	BN	رآامره	RE	MANYLAN
	Sta Registr		31. Date filed (Month, Day, Year MAY 1 2 20	32. Regist	rar's Signature	ede					•	21515

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		-	State of Maryland / Dep State Registrer  State of Maryland / Dep	artment of Health and Me	ental Hygiene	1115 16066
	Physici /Medio		1. Decedent's Name (First, Middle, Last)  Breadell Lunn/ Canol		2. Date of Death Month Day	05 5:55AM
	Examin	er	4a. Facility Name (If not institution, give street and number)  Joseph Richery House  5. Social Security Number 16. Sex 7. Age (In yrs. last birthday,		, ,	County of Death  Bull Ce Le  9. Birthplace (State or Foreign
	Funeral Director		220-64-53√2 1□ M 251F 44 Yrs. Usual Residence of Decedent	Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 3/16/56	
	e Marylan la-f show	ctor	10a. State 10b. County 10c. City, Town or L  Bulk-mo	v-e		10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	ath with th	Funeral Director	2628 Kent St.	10f. Zip Code 2/230		izen of What Country?  (L - S - American Indian,
920	72 hours after death with the Maryland natural; or items 23s or 28s-f show disal Examiner must be notified at	þ	11. Marital Status  1 Never Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto R 1 ☐ Yes X☐ No Specify:		Black, White, etc.  Specify: Black
21215-0036	within ene. than "	Completed	(Specify only highest grade completed) (Giv.	odent's Usual Occupation e kind of work done during most of workin DO NOT use retired) I STANT TEACHER	9	ind of Business/Industry
land 2	be filed Ital Hyg Id othe event,	To Be Co	17. Father's Name (First, Middle, Last)  ROBERT LUNN	ANNI		ES
, Maryland	12 sh h and 7 is m traum		CHARLES CARROLL HUSBAND 262	ing Address (Street and Number or Rural	O. MD. 23	1230
Baltimore,	Pages 1 ment of He ant: if iter ury or oth		1 General 2 Cremation 3 Removal from State  4 Donation 5 Dother (Specify) MT. ZI	ON CEM, 5/10		SDOWNE, MD.
Balt	permit. Pag Department Important: i eny injury o		21. Signature of Funeral Service Licensee  22. Signature of Funeral Service Licensee  23. Part1. Enter the disease, or complications the caused the death. Do not en			ME P.A. MD. 21217 Approximate
8760, <	law requires that the death certificate be executed  Example as been signed by the attending physician and as been signed by the attending physician and a should be detached for use as the burnat-transit	dical Examiner	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	ure		Interval Between Onset and Death
.O. Box 6	at the death certific by the attending pi	Physician/Medical		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
Ω.	quires that n signed by	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco 1 ☐ Yes 2	use contribute to the cause of death?
I Records,	The ate h page	Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No
on of Vital	ding Physician: n. After this certific funeral director,	To Be	25. Was case referred to medical examiner?  1 Yes 25 No Hospital: 1 Inpatient 2 ER/Outpatient 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 2 Research Rese			6 Onther (Specify) Hospice
Division	ai or Attendii s after death. ii Director: A id in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Street as City or Town, State	nd Number or Rural Route Number, e)
	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	edical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, dea control one)  1 Medical Examiner: On the basis of examination and/or and manner stated.	nvestigation, in my opinion, death occurre	ed at the time, date an	d place, and due to the cause(s)
)	To t To t	M	29b etgnature and title of certifier	29c. License number	5/	ate signed (Month, Day, Year) 4/05
	4	ate	30 Name and address of person who completed cause of death (Item 23a) (Type DR PR PU ARRA Solution 1) ARRA Solution (Item 23a) (Type 31. Date filed (Month, Day, Year) 32. Registrar's Signature	ph Pickey Hos	nce-B	Alto, mel.
	Regist		31. Date filed (Month, Day, Year) 32. Registrar's Signature	K)		

BRENDELL

LIE L. CORBIN

Division of Vital Records, P.O. Box 68760,

			Please	Type or Pri					_		egible.	
			for State Registrar	State of Ma	arylanu /	-	tificate of	lealth and M <i>Death</i>		giene Reg. No	000	10007
	Physici		Decedent's Name (First, Middle, Lecil)  Nellie Lucil						2. Date of De		2005	S. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, g		1 -		4b. City, Town, o	r Location of Death	TI IFT	4c. C	ounty of Death	1 - 2) DE 17
i	Funeral		,	Sex 7. Ag	e (In yrs. last L		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th y, Year)	Cour	
-	Director		215-22-5806 Usual Residence of Decedent		78	Yrs.			May 19	, 192		ginia
	Marylar -1 show fied at	tor	10a. State 10b. County  Maryland Balti	nore	10c. City, To	wn or Loc ngsvi					1	0d. Inside City Limits 1 ☐ Yes 2 ☐ Xo
	death with the Maryland ims 23a or 28e-f show ims Lee Indiffed at	Directo	10e. Street and Number			.19.0 1	10f. Zip Code	7			en of What Cour	ntry?
	ems 23	Funeral	11211 Cedar Lai	12. Was Decedent Armed Forces?	Ever in U.S.	13. W	21087 as Decedent of H	/ lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.)		SA . Race - Americ Black, White,	
2-0030	be filed within 72 hours after death with the Marylan be filed with Hygiene.  do other then "neturel; or Items 23a or 28e-f show event, I'm Marifeal Erain and Itlust Learndiffed at	by	1 ☐ Never Married 2 📆 Married 3 ☐ Widowed 4 ☐ Divorced				☐Yes 🎾 No	Specify:	, , , , , ,	S	necify:	White
2	in 72 ho "netur	Completed	15. Decedent's (Specify only highest of	rade completed)		(Give k	ent's Usual Occup ind of work done O NOT use retired	durina most of work	ing	16b. Kind	of Business/Inc	
V	filed with Hygiene. other ther ent, the N	Comp	Elementary/Secondary (0-12) 12	College (1-4or 5		Admir	istrativ	<i>r</i> e Assista			. Gover	nment_
=	uid be fii dental H rked otl tic even	To Be	17. Father's Name (First, Middle, La.  Roy David I	i				18. Mother's Name			<sub>umame)</sub> parks	
Mary	d 2 should be th and Mental 7 Is marked traumatic ev	-	19a. Informant's Name/Relationship Raymond Corbin,		- 1			and Number or Run Lane, Kine				Code)
ore,	permit. Pages 1 and 2 should Department of Health and Men Importent: If Item 27 Is marke any injury or other traumatic once.		20a. Method of Disposition  1 Surial /2 Gremation 3		20b. Place	of Dispos	ition (Name of atory or other place		JSVIIIE		ation - City or To	wn, State
	nit. Pages artment of l ortent: If it injury or o		'4 □Donation 5 □ Other (Spec 21. Signature of June 1 Service Lice	city	Bel A			Grdns 5-10			ir, Mar	yland
Ď	permit. Departri Importe any inju	10	JA NA	rs to	-	13	17 Cokes	ineral Horsbury Road	d, Abin	gdon,	Maryla	
1	Physician •	V.	23a. Party. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition	mplications that caused by one cause on each li	the death. Do	toa a	0 ,	ig, such as cardiac o				Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence	e of):	1001	043700	V(1) (400			year
	D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a consequence	e of y						
o o	be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a consequence	e of):					-	
	cate be physicia s the bur	dicai		d.		-						
XOC	ath certif tending or use a	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth		th 3□E	Ectopic pregnancy	,	****	230	d. Date of delive	ry Day Year
5	t the deg by the a ached fo	hysici	1 Yes 2 No	4☐ Pregnant at 9☐ Unknown	time of death	5 🗌 (	Other (specify)	_			World	Day rear
7,50	The faw requires that the death certificate the has been signed by the attending physicage 2 should be detached for use as the light.	by	Part II. Other significant conditions	contributing to death b	ut not resulting	in the und	derlying cause giv	en in Part I.	23e. Did to	_		e cause of death?
spiosau	2 2 2	pleted	1// 10/04/	7	7 0 7	V/¥1			24a. Was	an :	24b. Were autor	osy findings available
	rsicien: The law s certificate has b firector, page 2 s	e Compl	25. Was case referred to medical	,				OS Place of Poets	1 Tyes	med? 20 No	death? 1 🗌 Yes	
7	Physicien: rthis certific ral director,	To B	examiner? 1 🗆 Yes 2 No	Hospital:		Outpatient		4 LN Inursing Ho	me 5 Resid	lence 6 [		')
	Attending Physic death. ector: After this by the funeral directions.	Certification:	27. Manner of Death  1 Anatural 5 Pending 2 Accident investigati		y Year) 28b.	Time of Injury	28c. Injun Worl M 1	y at k? Yes 2 □ No	28d. Describe h	iow injury o	occurred	
	f or Atter de after de Directo	ertific	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	be d 28e. Place of Injuding, etc		farm, stree	et, factory, office		28f. Location (5 City or Tow		Vumber or Rura	l Route Number,
	To the Hospitel or Aftending Physicien: The within 24 hours after death.  To the Funerel Director: After this certificate his completely filled in by the funeral director, page	edical C	Check only 2 Medical Ex	Physician: To the best aminer: On the basis of	t examination a	ge, death o	occurred at the tin	ne, date and place, pinion, death occurr	and due to the o	ause(s) ar	nd manner as st	ated. the cause(s)
	To the within 2 To the complet	Med	one) 29b. Signature and title of certifier	and manner sta	ated.		29c. License				signed (Month, I	
	/		20 Name and address of access in	/VVV	inn	) (Time 7	D2	7975		5/	7/05	
	2	1	7.7	we wy	615	MOC	Phend,	nd he	I Am	run	2/01	4
	Sta Registr		31. Date filed (Month, Pay, Year)	2005 Registra	ar's Signature	Sport	All I					

			For State Registrer	State of	Maryland		irtment of F tificate of		Mentai Hyg	giene Reg. No.		15050	
	- · · ·		Decedent's Name (First, Middle, Las	")					2. Date of Dea	ıth in the	10	3. Time of Death.	
	Physici /Medio			agdeline		hilds			Month May	4, 20	005	12:50 PM	
	Examir	ıer	4a. Facility Name (If not institution, give				4b. City, Town, or Location of Death			4c. County		7	
	Francis		Quail Run As:  5. Social Security Number 6. Se		LIVING '. Age (In yrs. Ia	ast birthday)	Bel Air			1	Harford  9. Birthplace (State of		
	Funeral Director			□M 2[ <b>X</b> F	93	Yrs.	Months Days	Hours Min.	(Month, Day	5, 1911	Coul	unsylvania	
	pu s		Usual Residence of Decedent  10a. State 10b. County		10c City	, Town or Lo	cation					0d. Inside City Limits	
	Maryla fed al	Į.		ford		,	Bel .	Air				1 XYes 2 No	
	r 28a	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of V	Vhat Cour	ntry?	
	th with	al D	406 East Broad	vay Exte	ended		2	1014			USA		
	be filed within 72 hours after death with the Maryland Hygiene. d othar than "natural", or itams 23a or 28a-f show a othar than "natural", or itams 23a or 28a-f show evant, "the Madical Exattrities" intended at	Funeral	11. Marital Status 12. Was Decedent Armed Forces?			S. 13. V	Vas Decedent of H Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puer	pecify Yes or No- to Rican, etc.)		14. Race - American Indian, Black, White, etc.		
39	urs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 <b>XX</b> No If Yes, Give Year <i>o</i> r Dates:		1	☐ Yes 21 No	Specify:		Specify	hite		
21215-0036	72 hor	sted	15. Decedent's Edi (Specify only highest grad		16a. Deced	ent's Usual Occup	16b. Kind of Bu	Bb. Kind of Business/Industry					
121	within ne. han "	Completed	Elementary/Secondary (0-12)	4or 5+)	life. L	OO NOT use retired	d) -	Or To Tioms					
S			17. Father's Name (First, Middle, Last)				Homemak		me (First, Middle,	Own Home  Maiden Sumame)			
Maryland	should be filed ind Mental Hygi marked othar umatic evant, I	ro Be	Adam Charles I	:			es Fur	Funk					
lary	a se se		19a. Informant's Name/Relationship (T						ural Route Number				
	of Health itam 27		Cyril V. Childs, 8	son	20h Pis		Ivy Bus.		Columbia	-		21044	
altimore,	Pages nent of H int: If its iry or of	124	1 Surial 2 □ Cremation 3 □ Cr		tate Ce	metery, cren	atory or other plac		/ <b>,</b> 2005	20c. Location - Bel Air	•		
altir	permit. Pages Department of Important: If it any injury or one	1	21. Sun ture of Funeral Spry de Licens		BeT	22	emorial (	ss of Facility		ET AIL	Mal	yranu	
m	Deg e d		McComas Funeral Home, P.A.  50 West Broadway Street, Bel Air, Maryland 21014										
l.	nysician /Medical		23a. Part 1. Entire the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate Interval Between										
			Immediate Cause (Final disease or condition resulting in death)  a. ATHEROSCIEROTIC CARBIOVASCULAR DISEASE TEN YEARS										
	Examiner			Due to (o	r as a conseque	ence of):						100	
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Dua to (u	f as a strisequi	ance of).	-						
V	acuted ind transii	Examine	Cause (Disease or injury that initiated events resulting in death) Last	c									
60,	icate be executed physicien and s the burial-transit	ai Ey	resulting in dodain) Last	r as a conseque	quence oi):								
		edicai		d									
Вох	The law requires that the death certifing to the been signed by the attending page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant	23c. If yes, outco	ome of pregnan	icy	Ectopic pregnancy			23d. Date	ery		
П	e deat he att	sicis	in the past 12 months?  1   Yes 2   No 9   Unknown							Mor	M <i>o</i> nth Day Year		
P.0	hat the de od by the a detached		9 ☐ Unknown*  Part II. Other significant conditions co	en in Part I	23e Did tol	hacco use contr	o use contribute to the cause of death?						
ecords,	uires that signed to id be deta	6								1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📆 Un			
COL	s been s shoul	Completed	24a. Was								n 24b. Were autopsy findings available		
Be	The lav ate has page 2	omb			perform	autopsy performed? death?  1 Yes 2 No 1 Yes 2 No							
Vital	cian: T ertificat ector, pa	BeC	25. Was case referred to medical examiner?				26. Place of Death (Check only one)						
of	Physician: this certificinal director,	T0	1 ☐ Yes 2 Nono  27. Manner of Death	Hospital: 1 In		R/Outpatient		4   Nursing F				Assisted	
		27. Manner of Death 28a. Date of Injury 28b. Time of 28b. Injury at 28b. Describe how injury occ Injury at 28b. Describe how injury occ Injury 4 Work?  M 1 Yes 2 No								ow injury occurre	ured Living		
Division	al or Attandi atter death. I Diractor: Al d in by the fu	Certification	3 Suicide 6 Could not be	28e. Place o	of Injury - At hong, etc. (Specify)	ne, farm, stre	et, factory, office		28f. Location (St City or Town	Street and Number or Rural Route Number,			
Ö	Hospital or Attanding 14 hours after death. Funaral Diractor: After tely filled in by the fune		To more	building	g, etc. (Opecny)				Only of Your	r, otate)			
	To the Hospital of within 24 hours at To the Funeral D completely filled in	edical	29a. Certifier 18 Certifying Phy (Check only one) 2 Medicel Exam	sician: To the b ner: On the bas and manne	sis of examination	rledge, death on and/or inv	occurred at the tinestigation, in my o	ne, date and place pinion, death occu	, and due to the carred at the time, d	ause(s) and mar ate and place, a	nner as st ind due to	ated. the cause(s)	
	To the within 2 To tha complet	Med	29b. Signature and title of certifier	and manne	ar stateu.		29c. License	e number	9d. Date signed	I. Date signed (Month, Day, Year)			
)	- s + ō		madelli	5 ad A	Con		d	35522		MAT 5, 2005			
	1		30. Name and address of person who c			23a) (Type, F	Print)						
	9		MARK WILD	2 NOR		ENVE	BEL	AIR.	MARYLA	IND =	21014	<i>i</i>	
	Sta Registr		31. Date filed (Month Ray, Year) 2 20	105	gistrar's Signat	To Asp							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 26 per dvr 3843 5-12-05 vt
State of Maryland 7 Department of Health and Mental Hygiene

			For State Registrar		State o	Maryla			it of H te of L		Mental H	ygien Reg. N	201	)5	16069	
	Physici	an	Decedent's Name (First, Middle, Last)     Date of Dea Month										ay	Year	3. Time of Death	
	/Medic		Hilda				Carro1				May	4,	2005		1:00 P M	
	Examin	er	4a. Facility Name (If not							Location of Dea	ath	4	c. County o			
	Funeral		Esther P3 5. Social Security Numb		ssited		g Baltimore rs. last birthday) If Under 1 Year   If Under 24 Hrs				s. 8. Date of E	Birth	N/A  9. Birthplace (State or Fore			
	Director		5. Social Security Number  215-50-9460  6. Sex  1 M 2XIF  7. Age (In yrs. last birthday)  1 Yrs.  1 Months  1 Under 1 Year  1 Under 1 Year  1 If Under 1 Year  1 If Under 1 Year  1 If Under 24 Hrs.  8. Date of Birth  Months  8/19/19									7491	Country) 13 England			
	w		Usual Residence of Dec 10a. State 10t	edent c. County		10c.	City, Town or Lo	ocation						10	Od. Inside City Limits	
	Maryli f sho	lor	MD	N/A			Baltimo								1 GYes 2 □ No	
	r 28a	Funeral Director	10e. Street and Number					10f. Zi	p Code			10g. C	itizen of WI	nat Count	try?	
1	11 with with 23a o	ai D	2831 Monte	bello I	errace				2121	4		Briti	an			
	tems termi	uner	11. Marital Status		12. Was Dece Armed Fo	rces?	U.S. 13.	Specify Yes or I	No-	14. Race - American Indian, Black, White, etc.						
36	filed within 72 hours after death with the Maryland Hygiene. Ither than "natural", or Items 23s or 28s-f show ant, the Markical Evantral must be notified at	oy Fi	1 ☐ Never Married 3 🖫 Widowed 4 ☐	_	1 □ Yes If Yes, Giv Year or Di	/e		1 🗆 Yeş	2 <b>[X</b> No	Specify:			Specify:	Whi		
Maryland 21215-0036	2 hou atura	Completed by	15.	Decedent's Ed	ucation	4163.	16a. Dece	dent's Usu	ial Occupa	ition		16b.	Kind of Bus	iness/Ind	ustry	
215	thin 7. e. an "n	pie	(Specify of Elementary/Secondary	-4or 5+)	(Give kind of work done during most of working life. DO NOT use retired)											
2	ygien ygien rer th	Соп	8 Homemak										Own Home			
and	be fill ntal H ad oth even	Be	17. Father's Name (First Thomas Jak								ame (First, Midd		n Sumame,	)		
2	hould d Mer marks matic	ဥ	19a. Informant's Name/		vne Print)		19h Mailie	na Addres	s (Street a		beth Par		City or Town, State, Zip Code)			
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Healin and Mental Hydiene.  Department of Healin and Mental Hydiene.  Department of Healine 27 is marked other than "natural", or flems 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified at once.		21. Signatur of Funera	I Service Licen:	see										home Inc.	
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	/Medical Examiner		resulting in death)		ue to (	or as cons	equence of):		1				)			
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٣.	res that t signed by be detact	y Ph	Part II. Other significan	t conditions co	ontributing to de	eath but not r	esulting in the u	nderlying	cause give	n in Part I.	23e. Dic	e. Did tobacco use contribute to the cause of death?				
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	To the Hospital or within 24 hours after to the Funeral Dir completely filled in a	Medical	29a. Certifier 154 (Check only one) 2	Certifying Phy Medicel Exam	/sician: To the iner: On the ba and mann	asis of exami	nowledge, death ination and/or in	h occurred vestigation	at the time n, in my op	e, date and place inion, death occ	e, and due to the curred at the time	e cause(s , date an	) and mann d place, and	er as sta d due to t	ted. he cause(s)	
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	12		30. Name and address of	of person who o	ompleted caus	e of death (If	tem 23a) (Type,	Print)								
	10		Dr. Irene				gh1and	Aven	ıe	Balti	more M	21	1224	··		
	Sta Registra		31. Date filed (Month, Da		2005 32. H	strar's Sig	mature .	hand								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. item/26 perMD G843 5/12/05 TT State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** Yeer 2:50pm м Joseph Anthony DeVance 5 5 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner NA 1101 Willinger Court Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 9-3-55 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1**√** M 2□ F 49 Yrs Director 215-64-9359 Md. Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Show en "naturel", or Items 23e or 28e-f shov Medical Examiner must be notified at Md. X□Yes 2□No NA Baltimore Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with 1101 Willinger Court 21202 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 3 Widowed 4 Divorced 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Be Completed by Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 100 State of Md. 12th grade Public Health Lab. Scientist . Pages 1 and 2 should be filed w tment of Health and Mental Hygie tent: If item 27 Is marked other t jury or other treumetic event, th 6 yrs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Daisy Joseph DeVance Norris 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Zenith McCoy Sister 1101 Willinger Court, Baltimore, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) permit. Page Department of Importent: If any injury or Once. King Mem. Park 5-9-05 Randallstown, Md. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Baltimore, Md. 21202 1101 E. North Ave. March F.H. East no one 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final pancreatic Priysician Metastatic months disease or condition resulting in death) /Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): P.O. Box 68760. physician s the burial Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? jo Month Day 5 ☐ Other (specify) 4 Pregnant at time of death been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 2X No 1 ☐ Yes 3 ☐ Probably 4 ☐Unknown 24a. Was an autopsy performed? 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? certificate 2 🗆 No 1 TYes or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: 2 1 Inpatient 2 ER/Outpatient 3 DOA After thi funeral of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: 1 Natural s after dea. 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 / Homicide To the Hospitel within 24 hours a

To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) RES-000 19/05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) , Baltimore, MD 2123 Broadwa Jie Yana 31. Date filed (Menth, Day, NA

DHMH 17 Rev 1/2001

State Registrar

strar's Signature

		1 - For State Registrar	State of	Maryland	-	artment o				giene Reg. No.?	105	16071	
Physic /Medi Exami	cal	1. Decedent's Name (First, Mic ADU 4a. Facility Name (If not institut	5	VALY ber)		4b. City, Tow	m, or Location	of Death	2. Date of Dea	Ö	Year O5 unty of Death	3. Time of Death	
Funeral Director		3012 Rices Lar 5. Social Security Number 218–36–1503		. Age (In yrs. las:		If Under 1 Your Months Da	SALTO ear If Under ays Hours	r 24 Hrs. Min.	8. Date of Birt (Month, Da) 03-16-	y, Year)	Coul	MORE  place (State or Foreign  ntry)  York	
e Maryland a-f show	ctor	Usual Residence of Decedent           10a. State         10b. Coun           Md         Balt	imore	10c. City, T		ocation stown						10d. Inside City Limits 1 ☐ Yes 2 No	
21215-0036  ad within 72 hours after death with the Maryland gjene.  er than "natural", or liems 23a or 28a-1 show it than Medical Evariner must be notified at	Completed by Funeral Director	10e. Street and Number  3012 Rices Lat  11. Marital Status  1 Never Married 2 M  3 Swidowed 4 Divorce  (Specify only high  Elementary/Secondary (0-12	ent Ever in U.S. es:  4or 5+)	in U.S.  13. Was Decedent of Hispanic Origin? (Spilf Yes, specify Cuban, Mexican, Puerto  1  Yes 2 No Specify:  16a. Decedent's Usual Occupation (Give kind of work done during most of work life. Do NOT use retired)					Specify: White				
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Baltimore, Maryls permit. Pages 1 and 2 should Department of Health and Mer Important: if tem 27 1s marks any injury or other treumatic ange.		19a. Informant's Name/Relatio  Gerald Daly  20a. Method of Disposition  1 Burial 2 Crematio 4 Donation 5 Other  21. Signature of Funeral Service	n 3 □Removal from Si (Specify)	20b. Plac	3012 e of Dispo etery, cre. 1awn	ng Address (Str 2 Rices Desition (Name o matory or other Cemeter 2. Name and Ad	Lane  f place)  ry  ddress of Facil	Randa Di 05-12 ity Lori	111stown 2-2005 ing Bye:	n, Man 20c. Locati Woodl rs Fur	cyland on - City or To Lawn, M neral D	21244	
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To the Hospital or Al within 24 hours effer or To the Funeral Direct completely filled in by	Medical	(check only one)  29b. Signature and tine of certifications	al examiner: On the bas and manne	is of examination	and/or in	vestigation, in m	e time, date any opinion, dea	ath occurred	d at the time, d	late and plac	manner as stoe, and due to	the cause(s)	
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amend item#19a, per Inf, 6845, 7/13/05 The State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death May 10, **Physician** Year Samuel G. Davis 2005 0950 /Medical 4a. Facility Name (If not institution, give street and number)
Upper Chesapeake Medical Center 4c. County of Death 4b. City, Town, or Location of Death Examiner Harford Bel Air Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 952 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 6. Sex 9. Birthplace (State or Foreign 1□M 2□F New York Yrs. Director 112-38-1874 52 Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits d 2 should be filed within 72 hours after death with the Marylan th and Mental Hygiene.
71 is marked other than "netural", or Itams 23s or 28e-f show traumetic event, the Medical Exactiver must be notified at Harford Belcamp 1 ☐ Yes 2 No Md. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21017 U.S.A. 4315 Foxglove Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates: þ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) trucking truck driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Josephine Manfredi Samuel Davis ပ a Informant's Name/Relationship *(Type, Print)* **kathleen A** <del>Cathy</del> Davis/wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health ar Department of Health au Important: If itam 27 Is any injury or other trau 4315 Foxglove Court, Belcamp, Md. 21017 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State May 14, 2005 Flushing, N.Y. Mt. St. Mary <sup>¹</sup> 4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** like disease or condition resulting in death) 60 /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Physician/Medical Examiner sician and burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): requires that the death certificate be Box ( IF FEMALE 23c. If yes, outcome of pregnancy
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4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 5 Other (specify) ed by the a detached f P.O. 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed be del Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. Completed by 1 Tes 2 No 3 Probably A Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes Vita Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes Z No ပို 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After or Attanding Natural 5 Pending within 24 hours after death.

To the Funarel Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation М 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifie (Check only one) tha 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0322 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6:5 5 DAV. 1) 31. Date filed (Month, Day, Year) 32. egistrar's Signature State

Registrar

Javis,

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

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25. Was case referred to medical examiner?		death e atte	O	in the past 12 months?	4□Pregnant	at time of death								Month [	Day Year	
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25. Was case referred to medical examiner?	, T	s tha ned l	۵.	Part II. Other significant condition	ons contributing to death	but not resulting i	in the un	derlying ca	use give	on in Part I.		23e. Did t	obacco (	use contribute to the	cause of death	1?
25. Was case referred to medical examiner?	ğ	quire n sig uld b										10.	Yes 2	□No 3□Proba	bly 4. Unkn	own
25. Was case referred to medical examiner?  1   Yes   2    3	s bee	lete									24a. Was	an	24b. Were autop:	sy findings avail	iable	
25. Was case referred to medical examiner?  1   Yes   2    ב	he la e has age 2	E I									autor	osy	prior to com death?	pletion of cause	of	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  DR. STANLEY M. KMAN, 1308 BUSINESS CENTER WAY, EDGEWOOD, MD 21040	Ö	ificat or, pë		25 Was case referred to medical						00 Bl				1 ☐ Yes 2	No.	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  DR. STANLEY M. KMAN, 1308 BUSINESS CENTER WAY, EDGEWOOD, MD 21040	>	sicia s cart lirect	m	examiner?	Hospital:	tiont all EB/O	stantions	a 🗆 no 4	Othe							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  DR. STANLEY M. KMAN, 1308 BUSINESS CENTER WAY, EDGEWOOD, MD 21040	5	Phy or this oral d	h-		28a. Date of In	jury 28b.		1440								
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  DR. STANLEY M. KMAN, 1308 BUSINESS CENTER WAY, EDGEWOOD, MD 21040	5	ding th: Afte	tior	Natural 5 Pending (Month, Day Year) Injury Work?									,=,=.	,		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  DR. STANLEY M. KMAN, 1308 BUSINESS CENTER WAY, EDGEWOOD, MD 21040	2	Atter dea ctor y the	fica	3 Suicide 6 Could	not be an Place of It	njury - At home, fa	arm. stre	et. factory.				f. Location (	Street an	nd Number or Rural	Route Number	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  DR. STANLEY M. KMAN, 1308 BUSINESS CENTER WAY, EDGEWOOD, MD 21040	2	after Dire	erti	4  Homicide determ	building, e	etc. (Specify)			511.00						Todato Flattibor,	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  DR. STANLEY M. KMAN, 1308 BUSINESS CENTER WAY, EDGEWOOD, MD 21040		Hospita 4 hours Funera ely fille		Check only 2 Medical	ig Physician: To the bes Examiner: On the basis	t of my knowledge of examination ar	e, death	occurred at	t the tim	e, date and	d place, and	d due to the	cause(s)	and manner as sta	ted.	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  DR. STANLEY M. KMAN, 1308 BUSINESS CENTER WAY, EDGEWOOD, MD 21040		thin 2 the I mplet	Med	5,10,	and manner s	stated.										
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  DR. STANLEY M. KMAN, 1308 BUSINESS CENTER WAY, EDGEWOOD, MD 21040		F 3 5 8		De s	7										49, 10dl)	
DR. STANLEY M. KMAN, 1308 BUSINESS CENTER WAY, EDGEWOOD, MD 21040				13003	200				5 CA	227	)		m	29 3,20	2007	
State 31. Date filed (Month, Pay Year) 32. Resistrar's Signature		5		DR. STANLEY M.	KMAN, 1308				WAY	, EDG	GEWOOI	O. MD	210	040	٠	
		Sta Registra	te ar	31. Date filed (Month, Day, Year)	2 2005 32. Reds	trar's Signature		barte	,			,				

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) UBI **Physician** 2005 LANCHE /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a Fecility Neme (If not institution, give street and number) 3700 Examiner SINOR 00 If Under 24 Hrs. If Under 1 Year Months Days 8 Date of Birth (Month, Day, Sept 3, 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 7. Age (In yrs. last birthday) Days Hours **Funeral** 1□M 200 F 1905 Sept Yrs. Director Usuel Residence of Decedent 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours aftar death with the Manyland Depertment of Hastilh and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23s or 28s-f show eny intury or other traumatic event, the Medical Experiment must be notified as 10c. City, Town or Location 10b. County 10a. Stete 1 ☐ Yes 2√ No Director Silver Spring Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street end Number 20906 USA 3700 International Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. . Was Decedent Ever in U,S. Armed Forceş? 1 ☐ Yes 2 ②No It Yes, Give Yeer or Dates: 11. Maritel Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Saltimore, Maryland 21215-0020 Specify. white ģ 3 NWidowed 4 Divorced 16b. Kind of Business/Industry Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) U.S. goverment unk unk statistical clerk unk 18. Mother's Name (First, Middle, Maiden Surname) unk 17 Father's Neme (First, Middle, Last) ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. tnforment's Name/Reletionship (Type, Print) Box 856 Sterling, VA 20167 Susan Houser/great niece 20b. Plece of Disposition (Name of cemetery cremetory or other) Dete 20c. Location - City or Town, State 20e. Method of Disposition etery, cremetory or other place) 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 📉 Other (Specify) In State Konald Sicensee State And tomy Board 655 W. Baltimore Street Director Baltimore, MD 21201 Enter the disease or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, or heart tailure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner attending physician and for use as the bunal-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in death) Last Division of Vital Records, P.O. Box 68760 by Physician/Medical Due to (or as e consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. been signed by the should be detached 3 Probably 4 Unknown 1 Yes 2 No 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? this certificata has 1 ☐ Yes 2 ☐ No 1 🗆 Yes 2 No Be 25. Wes case reterred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Yes 2 No To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi complataly filled in by the funeral 27. Mennet of Death 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. tnjury et Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation neral Director: A 1 Tyes 2 □ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier Medical (Check only

State Registrar

one) 29b Signature

30. Name and address of pe

31. Date filed (Month, Day, Year) MAY 1 2 2005

d title of certifie

MERATIONAL DR HZII, LILVERLPRING,

who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Dey, Year)

			For State Registrar	State of Maryla		artment <i>rtificate</i>				giene	005	16075
			Decedent's Name (First, Middle, Las	t)					2. Date of Dea	ıth		.3. Time of Death
	Physici		Ruth	Pear	1		Edmo	onds	Month Mav	04	2005	11:09p <sup>M</sup>
	/Medic Examir		4a. Facility Name (If not institution, give		-			Location of Deal			county of Death	111.090
			2327 W. Le	xingtin S	+	Bal	timo	ore				
	Funeral Director		21209001		. last birthday) Yrs.	If Under Months		If Under 24 Hrs Hours Min.		Year) (9	9. Birth Cou GA	
	and *		Usual Residence of Decedent  10a. State 10b. County	10c C	ity, Town or Lo	cation						10d. Inside City Limits
	Aaryla Sho	ō										1 ☑ Yes 2 ☐ No
	286-1	Director	MD NA  10e. Street and Number	1	Baltim	10f. Zip	Codo		1	I Om Ciain	on of What Cou	
	with e or					TOL. ZID						•
	eath	era	2327 West Lexir	1gton Street  12. Was Decedent Ever in l		Was Deced		L223	nacify Yes or No-		U.S.A.	
	fter d	Funeral	1 ☐ Never Married 2 ☐ Married	Armed Forces?	10. 1	Yes, spec	ify Cubar	, Mexican, Puer	Specify Yes or No- to Rican, etc.)	1	Black, White,	
8	urs a	by	3 X Widowed 4 □ Divorced	1 ☐ Yes    No If Yes, Give Year or Dates:	1	I□Yes 2	X No	Specify:		S	Specify: Bl	ack
Ö	be filed within 72 hours after death with the Maryland tal Hygiene. do other then "neturel", or items 23e or 28e-1 show event, the Medical Evarriner must be routiled at	Completed	15. Decedent's Ed		16a. Deced	lent's Usua	I Occupa	tion		16b. Kind	of Business/In	
215	within 7 ene. then "n	ple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	kind of wor DO NOT us	k done di e retired)	uring most of wo	rking			,
21	d withir giene. er then	NO.	5th grade	na		Home	make	r			House	
힏	be filed ital Hygi id other event, t	Be (	17. Father's Name (First, Middle, Last)					18. Mother's Na	me (First, Middle,	Maiden S		
<u>a</u>	uld b Aentz rked rtic e	ToE	Lannie Shanks				I	illian	Louis			
Maryland 21215-0036	s 1 and 2 should be f Health and Mental item 27 Is marked other treumatic ev	ľ	19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailin	g Address	(Street a.	nd Number or R	ural Route Numbe	r, City or 1	Town, State, Zîp	Code)
	2 = 12 tr		Robert Shanks-S	Son	3734	Cla	rint	h Road	, Balti	more	e, Md	21215
Baltimore,	of Hea		20a. Method of Disposition	20b.	Place of Dispos cemetery, crem	sition (Nam	e of her place	)	Date		ation - City or To	
Ĕ	permit, Pages Department of I Importent: If it any injury or or		1 ☐ Burial 2 ☐ Cremation 3 ☐ '4XXX onation 5 ☐ Other (Specify	nemoval moni State				1	4/26/05	Ow:	ings M	ills, Md
a	mit. partin sorte r inju		21. Signiture of Funeral Service Licens		22	. Name and	Address	of Facility	1,20,02	, O W .	ingo ii	IIIS/ Na
m	permi Depa Impo any ir once.		Ollyme A	. Thompson		arch	F/H	West	, Balti	m o 10	ь ма	21215
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the dea	th. Do not ente	or the mode	of dying	, such as cardia	c or respiratory arr	est,	e Ma	Approximate
	Physician		Immediate Cause (Final	•	/ "	/						Interval Between Onset and Death
}	/Medical		disease or condition resulting in death)	a. UGVGVGN  Due to (or as a conse		cer	<del></del>					Syn
	Examiner				4001100 01).							
		er	Sequentially list conditions, if any, leading to immediate cause (Disease or injury that in the department of the conditions  if any conditions of the condi	Due to (or as a consec	quence of):							
$\sqrt{}$	uted d ansit	Examiner	Cause (Disease or injury that initiated events	С.								
ó	exection and and rial-tr	Exa	resulting in death) Last	Due to (or as a consec	quence of):							
8760,	icate be executed physician and s the burial-transit	dlcal		d								
Ö	tifica ig ph as th	ed										
Вох	eath certific attending p	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregn		C-+:				230	d. Date of delive	ery
	deat e atte	icla	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 Fet		Ectopic pre Other (spe				ş.	Month	Day Year
0	that the de led by the a detached	hys	9 🗆 Unknown	9□ Unknown								
ď.	The law requires that the death certifit are has been signed by the attending page 2 should be detached for use as	by P	Part II. Other significant conditions co	ntributing to death but not re-	sulting in the un	derlying ca	use giver	n in Part I.	23e. Did to	oacco use	contribute to the	ne cause of death?
ğ	w require been sig should b	edt							1 □ Y	s 2 🗆	No 3 ☐ Prob	ably 4 Unknown
Records,	as been 2 should	Completed							24a. Was a		24b. Were auto	psy findings available
	The lav	шо							autops	ned?	death?	mpletion of cause of
Vital		a	25. Was case referred to medical					26. Place of Dea	1 ☐ Yes	No	1 ☐ Yes	ZLŲ NO
	ysicien: is certific director,	To B	examiner? 1 □ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient	3 DO	Other				Other (Specifi	u)
Division of	g Physer this seral di		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of		c. Injury		28d. Describe ho			,,
0	ttendin death. stor: Aft the fur	atlo	1	(WOINT, Day 18a)	Injury	М		es 2 🗆 No				
<u> </u>	ar de ecto	tife	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, stre	et, factory,	office		28f. Location (St City or Town		Number or Rura	l Route Number,
ā	tel or A s after el Dire ed in b	Certification:		ballaling, atc. (Open	· <b>y</b> /				Only or rown	i, State)		
	To the Hospitel or Attending Physicien: within 24 hours alter deals as a feet this certific completely filled in by the funeral director,	Medical	29a. Certifier 1 Certifying Phy (Check only one)	rsician: To the best of my knoiner: On the basis of examination and manner stated.	owledge, death ation and/or inv	occurred a estigation,	it the time in my opi	o, date and place nion, death occu	, and due to the carred at the time, d	ause(s) ar ate and pl	nd manner as st ace, and due to	ated. the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifie			29c.	License	number	2	9d. Date s	signed (Month,	Day, Year)
)			) XAJIS	2			75	345		3	5/4/05	
	./		30 Aame and ad ress of person who c	ompleted cause of death firm	m 23a) (Type. F	Print)				^		
	12	. 1	Partert Solut	ird Diss	W /	100	1)	Was D	the o	Bo	H m	21287
	Sta	te	31. Date filed (Month, Day (194) 1	7005 <sup>32</sup> . Registrar's Sign	ature &	ha.				V.V.	J-W 111	10100
	Registr		MULI TY	LUUJ KILLENS	10 /	1						

			1 - State Registrar		,	Certificate of	Death	R.	eg. No.	]5	1607
ı	Physici	an	1. Decedent's Name (First, Middle, L					2. Date of Deat Month	th Day	Year	3. Time of Death
	/Media	cal	Robert J. Fran							005	0725
	Examir	ier	4a. Facility Name (If not institution, g	ve street and number)	1 Ash	4b. City, Town, o	r Location of Death		4c. County	of Death	•
	Funeral		5. Social Security Number 6.	Sex 7. Age (	In yrs. last birt		If Under 24 Ars.	8. Date of Birth (Month, Day,			place (State or Forei
	Director		212-28-4068	1⊠M 2□F	77	rs. Months Days	Hours Min.	Aug 14,	1927	Coui	y Land
	put &		Usual Residence of Decedent  10a. State 10b. County	1	Oc. City, Town	arl costing					
	faryla sho	ō	MD Baltir	1	-	Baltimore				1	10d. Inside City Limit 1 ☐ Yes 2 X N
	28a-1	Director	10e. Street and Number	iore		10f. Zip Code		1	0g. Citizen of V	Albat Cau	
	3a or		3905 Darleigh R	oad			236	'	US		riuy r
	ms 2	Funeral	11. Marital Status	12. Was Decedent Eve	er in U.S.	13. Was Decedent of H		ecify Yes or No-			can Indian,
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "netural", or items 23a or 28a-f show early injury or other traumatic event, Ita Madical Examinar must be multiped at once.	by	1 □ Never Married 2K Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates:	45 <b>–</b> 46	If Yes, specify Cubi	an, Mexican, Puerto	Rican, etc.)		k, White, whi	
5-	72 h	Completed	15. Decedent's E (Specify only highest g	ducation ade completed)	16a.	Decedent's Usual Occup (Give kind of work done	during most of work	ting	16b. Kind of Bu	siness/In	idustry
121	within ane. Ihan	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)		life. DO NOT use retired	d)				
2	filed v Hygie ther t		12 17. Father's Name (First, Middle, Las	<u>(</u>	L	etter carri	er 18. Mother's Nam	a /First Middle A	postal		vice
aŭ	d be ental ced o	To Be	Ferdinand Fran					sephine		,	
3	shoul nd Mari	F	19a. Informant's Name/Relationship		19b.	Mailing Address (Street					a Code)
	nd 2 alth a 27 ls		Gloria Franz/s	pouse		005 Darleig				236	,
Baltimore,	Pages 1 a ent of He nt: If Item ry or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 14 ☒ Donation 5 ☐ Other (Spec	☐Removal from State	20b. Place of cemetery	Disposition (Name of r, crematory or other place		Date 2	20c. Location -	City or To	own, State
Balti	permit. I Departm Importar eny injur		21. Sixul ure of Funeral Service Lice Rona I i S		tor	22. Name and Addre State Anat Baltimore,	ss of Facility Omy Board MD 2120	 L 655 W.	Baltimo	ore S	Street
			23a. Park. Enter the disease, or cor	nplications that caused the	e death. Do n				est,		Approximate
	Physician		shock or heart failure. List only Immediate Cause (Final	ASA U	ID						Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a c	7	f):					
	Examiner		Sequentially list conditions	h							
	D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a c	onsequence o	n):					
	ecute and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c							
Ď,	be ex ician burial			Due to (or as a c	onsequence o	0):					
09/89	physics the	Medical		d							
C. BOX	at the death certificate be executed by the attending physician and tached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	Fetel death	3 □Ectopic pregnancy 5 □ Other (specify)	,		23d. Date Mor	e of delive	ery Day Year
Ţ.	g 8 9	y Ph	Part II. Other significant conditions	contributing to death but n	ot resulting in	the underlying cause give	en in Part I.	23e. Did tob	acco use contri	bute to th	he cause of death?
202	quires n sign uld be	d b	COPD					1 □ Ye	s 2□No	3 Prob	pably 4 Dünknowr
Hecords	law requir as been si 2 should	ompleted by	diverticulities					24a. Was an	24b. V	√ere autor	psy findings available
	The la	mo						autopsy	pled? d	rior to cor eath? □ Yes	mpletion of cause of
VII		Se C	25. Was case referred to medical				26. Place of Deatl	1 Yes 2	T	1195	2 LI NO
> 10	d is	To B	examiner? 1 □ Yes 2 ②No	Hospital: 1 Inpatient	2 ER/Out	patient 3 DOA Oth		me 5 ☐ Resider		r (Specify	y)
	ding Ph h. After th funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yo	28b. Ti	me of 28c. Injury	y at k?	28d. Describe ho	w injury occurre	d	
<u>s</u>	Attending ir death. ector: After by the fune	cati	2 Accident Investigation 3 Suicide 6 Could not I	10			Yes 2 □ No				
JIVISION	l or Atten after deati Director: in by the	Certification:	4 Homicide determined		- At home, farr Specify)	n, street, factory, office		28f. Location (Str. City or Town,	eet and Numbe , State)	r or Rura	I Route Number,
	spitel ours neral filled		29a. Certifier 1 ☐ Certifying P	nysician: To the best of m	v knowledge	death accurred at the tim	and data and place	and due to the on			
	within 24 ho To the Fun completely	edical	(Check only 2 Medical Exa	miner: On the basis of ex and manner stated	amination and	or investigation, in my of	pinion, death occurr	ed at the time, da	te and place, a	nd due to	the cause(s)
	within 2 To the comple	Me	29b. Signature and title of certifier	0		29c. License	e number	29	ld. Date signed		Day, Year)
	1/2		> Jolal las			H665	9365		5/9/0	5	
	181		30. Name and address of person who	completed cause of death	n (Item 23a) (T	ype, Print)					
			JOHN VISIC	LI PENI	NSULA	ype, Print) RICIONAL	MEDICAL	CENTER	SAL.	15BU	RY Md.
	Sta	te	31. Date filed (Month, Day, Year) MAY 1 2 2	Registrar's	Signature	Speciel		•			,
	Registr	ar	MINI TY C	SOUND THE STATE OF							

State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrer Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** ENWICK IGNATIUS MAY 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death HARL Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Birthplace (State or Foreign Country) Days Hours 1 1 M 2 □ F 217-32-3868 Usual Residence of Decedent Director 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 28e-f shov ust be redified at Completed by Funeral Director 1 ☐ Yes 2 ₽ No IECHANICS 10e. Street and Number 10g. Citizen of What Country? DRIA items 23a NITED Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) other treumatic event, the Medical Event were 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ If Yes, Give Year or Dates: 1953 - 1960 1 Yes 2 No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) ESMAN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Is marked of Be FENWICK HILDA LOUISE MARTIN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Importent: If item 27 Is eny injury or other tre once. SPOUSE BLOSOO ALEXANDRIA WAY MECHANICSVILLE, MD 2005 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 ☐ Cremation 3 Removal from State ANATOMY GIFTS REG. 5/6/05 \* 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Daugherty Family Funeral Home And Cremation Center, P.A. 2601 Mountain Road - Pasadena, MD, 21122 Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each line Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Cerebrovascul disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner advanced Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner to (or as a consequence of) Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.0. 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use commoute to the cause of death? Division of Vital Records, þ hype shpidemio 2 No 3 Probably 4 Unknown Be Completed D. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 No Dysphagia 24a. Was an autopsy 1 ☐ Yes 20 25. Was case referred to examiner? medical 26. Place of Death (Check only one) 26 No Other Certification: To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manne of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 24 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 5/6/05 AMMOWALOW De060120 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 HOSPITAL RD. PRINCE FREDERICK, MD 20678 AHMAD WAEL HAGOTHMN 31. Date filed (Month, MAY 1 2 2005 State Registrar

		State of Maryland / Department of Health and Me	ental Hygier	1e2005 15070
		1- State Registramend ITEM #20b PER FH G843 5 PER #55 at 94 of Death  1. Decedent's Name (First, Middle, Last)	Reg. I	No. 3. Time of Death
Physic		DONNA CHRISTINA FARRINGTON		0.2005 7/8 pm
/Medi Examii		4a. Facility Name (If not institution give street and number)  4b. City, Town, or Location of Death	41	4c. County of Death
		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	Date of Birth	9. Birthplace (State or Foreign
Funeral Director		218-48-3242 10 M 22F 57 Yrs. Months Days Hours Min.	(Month, Day, Yes	947 MARYLAND
and		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Location		10d. Inside City Limits
Maryl	tor	MARYLAND NIA BALTIMOR	E CIT	1 ✓ Yes 2 No
death with the Maryland ms 23e or 28e-f ahow rmist be notified at	Funeral Director	10e. Street and Number 10f. Zip Code		Cilizen of What Country?
eath w	eral	2352 Mc CULLOH STREET 21217  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specific Property of Marital Status)	ifv Yes or No-	USA,
after d or Itan	Fun	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes, Specify Cuban, Mexican, Puerto Rill Yes, Specify Cuban, Mexican, Puerto Rill Yes, Give 1 Yes, Specify:	ican, etc.)	Black, White, etc.
id Z IZ IS-0050 sified within 72 hours after death w Hygiene. other than "netural", or frams 23e rent, I'ra Medical Exerpinet must	d by	3 Widowed 4 Divorced Year or Dates:  15. Decedent's Education 16a. Decedent's Usual Occupation	166	Specify: BLACK Kind of Business/Industry
hin 72	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  (Give kind of work done during most of working life. DO NOT use retired)	7	Kind of Business/mustry
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d be fill antal H red out	To Be	17. Father's Name (First, Middle, Last)  18. Mother's Name ( PERRY ALEXANDER FARRINGTON SR. ERNES		AUDE BROWN
ary and Mand a marl	-	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural)		
IOTE, INTERVISITION ZIZIONOSO ges 1 and 2 should be filed within 72 hours after death with the Marylan at of Health and Mental Hygiene. If item 27 is marked other than "netural", or Itams 23e or 28e-f ahow or other traumatic event, the Medical Examiner must be notified at	l s	ERNEST REED (CLOSE COMPANIAN) 2352 Mc CULLOH  20a. Method of Disposition (Name of Page 20)	ST. 1300	ALTO, MD 2/2/7 Location - City or Town, State
Pages 'Pages' nent of Find: If ite		1⊠Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place) 5/18/	2005	
Dallimo permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral Service Licensae  22. Name and Address of Facility	000	R. FUNERAL HOME
<b>n</b> 23553		Vietual N.Williams 2740 D. FULTON	JAVE.	BALTO, MO ZIZIT
25.5		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.  Immediate Cause (Final	respiratory arrest,	Approximate Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)  Due to (or as a consequence of):		
Examiner	L	Sequentially list conditions.  b. Due to (or see a consequence of):		
J pen r	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.		
ate be executed by sician and the burial-transit		resulting in death) Last Due to (or as a consequence of):		
oo / ou ificate be g physicial as the buri	edical	d		
Certing Iding	n/Me	IF FEMALE:  23b. Was decedent pregnant in the port 12 months?  23c. If yes, outcome of pregnancy  1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of delivery
de death the atter	Physician/M	in the past 12 months?  1   Yes 2   No 9   Unknown 9   Unknown		Month Day Year
ords, F.C. requires that the seen signed by the hould be detached.	/ Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death?
ecords law requires as been sign	ed by		1 ☐ Yes	2 No 3 Probably 4 Unknown
lawrenas ber	Completed		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
ar n n: The licate h: r, page			performed 1 Yes 2	? death? No 1 Yes 2 No
VITAI ysician: T s certificat director, pa	o Be	25. Was case referred to medical examiner?  1   Yes 2   No   Hospital: 1   Impatient 2   ER/Outpatient 3   DOA   Other: 4   Nursing Home		6 ☐Other (Specify)
n OT ng Phy Ifter this	on: T	27. Manner of Death  1. ON Natural 5 Pending (Month, Day Year)  28a. Date of Injury 28b. Time of 28c. Injury at Work?	d. Describe how in	
INISION  or Attending after death.  Diractor: After in by the function	ertification:	Accident investigation 3 Suicide 6 Could not be determined elemined to the suicide investigation 28e. Place of Injury - At home, farm, street, factory, office 28e.	Bf. Location (Street	and Number or Rural Route Number,
UIV safter safter al Dira	Certi	4 ☐ Homicide determined building, etc. (Specify)	City or Town, St	ate)
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Diractor: After this certific completely filled in by the funeral director,	dical	29a. Certifier 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, an (Check only one) 42 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated	d due to the cause d at the time, date a	(s) and manner as stated. and place, and due to the cause(s)
fo the within 2 fo the	Med	290 License and title of portifier 4 3 4	29d. [	Date signed (Month, Day, Year)
, ,,-0		Ali mirebrahimi mo 89548		5/10/05
5		Ali mirebrahimi mo 89548  30. Name and address of person who completed cause of death (Item 23a) (Type, Pript)  Ali Mirebrahimi mo No No No Maryland Grand	eral h	lospital_
St Regist	ate trar	31. Date filed (Month, Day, Year)  MAY 1 2 2005  MAY 1 2 2005		i j

			1 - State of M	-	artment of Health and M rtificate of Death		ene 9. No.: 0 0 5	16079
	Physici /Medio		Decedent's Name (First, Middle, Last)     ELLA ROMAINE	FRAMPI	ON	2. Date of Death Month MAY	Day Year 10, 2005	3. Time of Death  1:30 P.M
	Examin		4a. Facility Name (If not institution, give street and number) QUAIL RUN ASSISTED LIVING		4b. City, Town, or Location of Death NOTTINGHAM		4c. County of Death BALTIMORE	
	Funeral Director		5. Social Security Number  216-07-3327  G. Sex  1 M 2 TF  7. As  Usual Residence of Decedent	e (In yrs. last birthday) 94 Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, 4/7/191	Year) 9. Birthpl County MARY	ace (State or Foreign LAND
	ith the Maryland or 28e-1 show	tor	10a. State 10b. County  MD BALTIMORE	10c. City, Town or Lo			10	od. Inside City Limits
	with the I 3e or 28e- it be notifi	Funeral Director	10e. Street and Number 8633 ROCK OAK ROAD		101. Zip Code 21234	10	g. Citizen of What Count	ry?
36	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other then "naturel", or Items 23e or 28e-1 show or other treumatic event, the Medical Extra	by Funera	11. Marital Status  1 Never Married 2 Married  3 Xwidowed 4 Divorced  12. Was Decedent Armed Forces: 1 Yes 2 Xwidowed 4 Divorced	No	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - America Black, White, e	
21215-0036	within 72 hou ane. then "nature to Medical E	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or	(Give life.	dent's Usual Occupation kind of work done during most of work DO NOT use retired)	ing	6b. Kind of Business/Ind	ustry
	1.2 should be filed within h and Mental Hygiene. 7 is marked other then "reumatic event, the Men	To Be Co	8TH GRADE  17. Father's Name (First, Middle, Last)  JOSEPH B. RIGNEY	SALE		e (First, Middle, Mid.)  1. IMHOFF	aiden Sumame)	EPI. SIORE
, Maryland	1 and 2 shou Health and M em 27 is mar ether treumat	-	19a. Informant's Name/Relationship (Type, Print) BARBARA KAISER/DAUGHTER	har .	ng Address (Street and Number or Rura RESTVIEW AVENUE S	al Route Number,		Code) 1363
Baltimore,	Page 15		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State  1 ☐ Donation 5 ☐ Other (Specify)	WOODLAWN	CEMETERY 5/16	5/05 W	OC. Location - City or Tov OODLAWN, MD	
Ball	permit. Pag Department Importent: I any injury o		21. Signature of Funeral Service Licensee	8	2. Name and Address of Facility THE 521 LOCH RAVEN BLV	D. TOWS	ON, MD 212	86
8760,	Amedical Medical Examiner provided the burial-transit the burial-trans	al Examiner	Sequentially list conditions.	ne.	SFT AXILLA YMPHOEDE ARTELY DI			Approximate Interval Between Onset and Death
.O. Box 687	eath certific attending p for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown  23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	of pregnancy 2 Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of deliver Month	y Day Year
Ω.	quires that the d n signed by the uld be detached	by	Part II. Other significant conditions contributing to death t	out not resulting in the u	nderlying cause given in Part I.		acco use contribute to the	
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Division of Vital	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funerel Director: After this certificate completely filled in by the funeral director, page.	Certification: To Be	25. Was case referred to medical examiner?  1		nt 3 DOA Other: 4 Nursing Ho  f 28c. Injury at Work?  M 1 Yes 2 No	me 5 Residen 28d. Describe how 28f. Location (Stre City or Town,	vinjury occurred set and Number or Rural	ED LIVING  Route Number,
O	To the Hospitel or Attentwithin 24 hours after deatl To the Funerel Director: completely filled in by the	Medical Cer	29a. Certifier  (Check only one)  29 Medicel Examiner: On the basis of many many statements of the basis of t	f examination and/or in	h occurred at the time, date and place, vestigation, in my opinion, death occurr	and due to the cau	use(s) and manner as sta e and place, and due to	ited. the cause(s)
	To the within 7 To the comple	Mec	29b. Signature and title of certifier	0. MN	29c. License number	290	d. Date signed (Month, E	ay, Year)
<	5		30. Name and address of person who completed cause of a Sample (Chille	2140	Print) Place	Duna	dk 40 .	2/222
	Sta Registi	4.	31. Date filed (Month, Day, Year) MAY 1 2 2005	ar's Signature	W			

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	Physicia /Medic		1. Decedent's Name (First, Middle, Last)		FOEL	IRKO	LB	2. Date of Dea Month		2005	3. Time of 745	
	Examin		15tt 255	loso.	birthday) III	Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day NOV 28		N/A 9. Birth	olace (State or	Foreign
	Director		Usual Residence of Decedent	76 0c. City, To	Yrs.			NOV. 28	3, 19	28 Mary	Land Od. Inside Cit	y Limits
	r 28a-f sho	rector	MD. N/A			ALTIMOR	E	1	0g. Citize	en of What Cou	1 Yes	2 🗌 No
	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If item 27 is marked other than "naturel", or Items 23a or 28a-f show or other traumatic event, the Medical Examinat must be notified at	Funeral Director	3817 HUDSON STREET  11. Marital Status 1 □ Never Married 2 Married 1 □ Yes 2 Mo	er in U.S.		37	21224 lispanic Origin? (Spe an, Mexican, Puerto I			D STATE Race - Americ Black, White,	an Indian,	
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	and 2 sh salth and n 27 Is m er traum		19a. Informant's Name/Relationship (Type, Print) CHARLES FOEHRKOLB/HUSBAND	3	3817 H	UDSON S'	and Number or Rura T., BALTIN	MORE, MA	-			
Baltimore,	permit. Pages 1 a Department of He Importent: If iten eny injury or oth once.		1 V Burial 2 ☐ Cremation 3 ☐ Removal from State	ceme	ED HEA	ory or other place RT OF J ame and Addre	ESUS 5/13, ss of Facility CHA	/05 I ARLES S	BALTI ZEI	LER & S	RYLAND ON, IN	C.
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68760,	icate be executed physician and s the burial-transit	edical Exa	resulting in death) Last  Due to (or as a c	onsequenc	ce of):							
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Ś	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions contributing to death but r	not resulting	g in the unde	rlying cause giv	en in Part I.	23e. Did to		o contribute to the	ne cause of de eably 4 ⊟U	
al Record	The ate his page	Completed						24a. Was a autopoperfor 1 \( \supersection \) Yes	sy	24b. Were auto prior to co death? 1 \(\sum \text{Yes}\)	psy findings a mpletion of ca 2 No	vailable luse of
of Vital	Physicien: this certific ral director,	To Be	25. Was case referred to medical examiner?  1  Yes No Hospital: 1 Inpatient	2 □ ER/	Outpatient	3□ DOA Oth	26. Place of Death er: 4 ☐ Nursing Hor			Other (Specif	y)	
Division o	ing After une	Certification:	27. Manner of Death  Natural 5 ☐ Pending  2 ☐ Accident investigation  3 ☐ Suicide 6 ☐ Could not be	'ear)	D. Time of Injury		Yes 2 □ No	28d. Describe h			J. Dauta Numi	
Div	i gitt o		4 Homicide determined 238. Flace of Injury building, etc. (	(Specify) my knowled	dge, death o	curred at the tin	пе, date and place, a	City or Tow	n, State) ause(s) ai	nd manner as s	tated.	
	the the	Medical	(Check only one)  2 Medical Examiner: On the basis of exam manner states  29b. Signature and title of certifier	tamination	and/or inves	tigation, in my o				lace, and due to signed (Month,		
	With World		MBD regional MD	th (Item 23;	a) (Type, Pri	RE	SOOO		MAX	1 10.	1005	
	5		MACAM B SHARAND MD, Late filed (Month, Day, Year)  31. Date filed (Month, Day, Year)  32. Registrar's	20 NO	RTH WI	OLFE ST	REET, BALT	IIMORE	MAR	YLANC	212	67
DH	Sta Registi MH 17 Rev 1/2	rar	MAY 1 2 2005			ade						
	/ In				RIGINAL							

Thomas L. Green 05-2809 AKG

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend items 23a, 27 per me353, 3:-30-06 vt

	1	For State Registrar	State of Marylah			ate of De			Reg. N		1 3 .
sician edical		. Decedent's Name (First, Middle, Las Thomas Green	st)					2. Date of Month Apri		2005 Year	3. Time of Death 10:32 A M
miner ral		a. Facility Name (If not institution, giv 309 N. Fulton Ave . Social Security Number unk 6. S	nue	last birthday) Yrs.	Ва	ltimore	Cation of Deat Under 24 Hrs. Hours Min.	8. Date of		unk 9. Birth	olace (State or Foreigr ntry)
by Funeral Director	_	Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	ocation						10d. Inside City Limits
Director		MD				timore					1 □XYes 2 □ No
I Dir		Oe. Street and Number 309 N. Fulton	Avenue		10f.	Zip Code 212	23		10g. (	Citizen of What Cou USA	•
by Funeral		1. Marital Status unk 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in by Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:			cedent of Hispa cecify Cuban, I	anic Origin? (S Mexican, Puert	pecify Yes or o Rican, etc.	No-	14. Race - Americ Black, White,	can Indian,
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Be	1	7. Father's Name (First, Middle, Last)				unk 18	. Mother's Nar	ne (First, Mic	Idle, Maide	en Surname)	unk
To		19a. Informant's Name/Relationship ( $0 \cdot C \cdot M \cdot E$ .	Type, Print)				NumberorRu t Balti			or Town, State, Zip 21201	Code)
		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 💢 Other (Specif	Removal from State	Place of Disponentery, crea	osition (f matory o	lame of r other place)	1	Date	20c.	Location - City or To	own, State
		21. Signal II. of Euneral Societice Licer	Wade, Director	27	Stat Stat	and Address of Anato	my Boan MD 212	655 201	W. B	altimore	Street
Il Examiner		Immediate Čause (Final disease or condition resulting in death)  Sequentially list conditions, fany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Atheroscler Due to (or as a conseq b. Due to (or as a conseq c. Due to (or as a conseq	uence of): uence of):	Card	iovascu	lar Dis	sease			
by Physiclan/Medical		F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d	Ideath 3	□Ectopic □ Other	pregnancy specify)				23d. Date of delive	ery Day Year
		Part II. Other significant conditions o	ontributing to death but not res	ulting in the u	nderlyin	cause given i	n Part I.			use contribute to the	ne cause of death?
Completed	-							24a. V a p 1 \( \text{Y}\) \( \text{Y}\)	utopsy erformed?	24b. Were auto prior to cor death?	psy findings available mpletion of cause of 2□ No
o Be		25. Was case referred to medical examiner?  1 XYes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatier	* 20	044	6. Place of Dea			e Filitan (Cresit	1
atlon: To	4	27. Manner of Death  1 Natural 5 Pending  2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury		28c. Injury at Work?	2 No			<b>⊕</b> (∑)Other (Specify ury occurred	n at scene
Certification:		3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, str	eet, fact	ory, office		28f. Location City or	n (Street a Town, Sta	and Number or Rura te)	l Route Number,
Medical C		29a. Certifier 1☐ Certifying Ph (Check only one) 1☐ Medical Exam	ysician: To the best of my kno niner: On the basis of examina and manner stated.	wledge, deat tion and/or in	h occurre vestigati	d at the time, on, in my opinion	date and place on, death occu	, and due to rred at the tir	the cause( ne, date a	s) and manner as st nd place, and due to	ated. the cause(s)
Me		29b. Signature and title of certifier  DOUNTE	e Yhul	LW		9c. License nu	ımber			il 23, 20	
State	И	30. Name and address of person who AUGAR TO P	32 Registrar's Signa		Print)	111 Pe	nn Stre	et Ba	altim	ore, Mary	land 2120

ADH MICHAEL GROSS 05-3174

31/4			State of Maryland / Department of Heal State of Heal	ılth and Me 5,,‡as	ental Hyg	giene	100	0.0
			Hegistrar     Oertificate of Decinition     Decedent's Name (First, Middle, Last)	2	2. Date of Dea	ith	3. Time of E	Death
	Physici /Medic		MICHAEL GROSS		MAY	7, 2005 Year	1048	Ам
	Examin	er	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Loca  2934 W. COLDSPRING LANE  BALTIMORE			4c. County of Death	la.	
90	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If U		Date of Birth	9. Birth	place (State or intry)	Foreign
3	Director	1	214-70-9923 10 M 20F 46 Yrs. Months Days Ho	lours Min.	JUNE!	5,1958 191	7 RYLA	TNO
	yland		10a. State 10b. County 10c. City, Town or Location			,	10d. Inside City	/ Limits
	e Mar	ctor	MARYLAND NIA BALI	TIMOR	RE (	TITY	1 X Yes	2 🗆 No
	with the or 2	Funeral Director	10e. Street and Number	5 . 0		log. Citizen of What Cou	intry?	
	death rms 23	nera	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispan If Yes, specify Cuban, Me	nic Origin? (Speci	fy Yes or No-	14. Race - Amer		
36	ours after death with the Marylar ral', or Items 23a or 28a-f show Exercities troughed at	by Fu	1 Nover Married 2 Married 1  Yes 2 No	iexican, Puerto Hi <i>pecify:</i>	can, etc.)	Black, White	, etc.	
8			3 Wildowed 4 Divorced Year or Dates:  15. Decedent's Education   16a. Decedent's Usual Occupation		-	16b. Kind of Business/li	ACK	•
215	□ 2	Completed	(Specify only highest grade completed)  Give kind of work done during life. DO NOT use retired)  Flementary/Secondary (0-12)  College (1-4or 5+)	g most of working				,
121	Hygurithe It.		17. Father's Name (First, Middle, Last) COK	Mother's Name (I		BALTO, BEHI	AVIOR HE	ALTH
land	e d ia b	To Be	1	BARB			RR15	
Maryland 21215-0036	C1 02 28 88	-	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and N					,
e, ≥	s 1 and 3 if Health itam 27 other tra		ALVIN GROSS JR, (BROTHER) 2207/2 ALL 20a. Method of Disposition (Name of	ENDAL		BALTO, MI		16
JÖ.	ages ant of I it: If its y or o		1. Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place)			20c. Location - City or T		
Baltimore,	permit. Pag Department Important: I any injury o		. 4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee  22. Name and Address of	Facility 1	-05 L	ANS DOWNE	VERA!	Home
-	89 = 9		Dienich N. William 2140 N.	1-ULTO	NAVE	1, 13ALTO,	MD 21	217
	w =		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line. Immediate Cause (Final	ich as cardiac or r	espiratory arr	es(,	Approximate Interval Betwo Onset and De	een
	rnysician /Medical		disease or condition resulting in death)  Cocaine Intoxication  Due to (or as a consequence of):					_
	Examiner							
J	pet lisit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (1833) of injury that initiated events c.					
, ,	execu in and rial-tra	Examiner	that initiated events c.  resulting in death) Last Due to (or as a consequence of):					
8760	cate be executed ohysician and the burial-transit	Physician/Medical	d					
9	certificanding plans as t	/Med	IF FEMALE: 23b. Was decedent progners. 23c. If yes, outcome of pregnancy				-	
. Box	death e atten d for u	ician	in the past 12 months?  1  Live birth 2 Fetal death 3 Ectopic pregnancy 1  Yes 3 No.  4 Pregnant at time of death 5 Other (specify)			23d. Date of deliv Month	ery Day Ye	ar
P.0	requires that the death certific een signed by the attending p hould be detached for use as	Phys	9 □ Unknown					
	es pe	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in F	Part I.	23e. Did tot	pacco use contribute to t es 2 €No 3 □ Prof	he cause of dea pably 4 ⊡Un	
COL	× 0 0	Completed			24a. Was a			
Re	The law ate has b page 2 si	Comp			autops	y prior to co	mpletion of cau	ise of
Division of Vital Records,	Physician: The this certificate ral director, pag	Be	examiner?	Place of Death (C				
of	Phys this aldi	T. To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at	☐ Nursing Home		tai		<u> </u>
ion	ath. r: After the funeral	atior	27. Manner of Death  1 Natural  2 Accident  1 Accident  28a. Date of Injury  Found  10.20  A M  28b. Time of Work?  1 Yes			t and any assumed to	ınk	
ivis	or Atta	Certification;	3 ☐ Suicide 4 ☐ Homicide  6 ♣ Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	281	Location (St. City or Town	reet and Number of Rura n, State <b>2934 W.</b>	Coldspi	ing.
	spital ours al		Found at home  29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date the time of the control o			timore, Md	Anh. J	
	To the Hospital or Attanding I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, and manner stated.	n, death occurred	at the time, da	ate and place, and due to	tated.  the cause(s)	
	To the	Σ	29b. Signature and title of certifier 29c. License num	nber		9d. Date signed (Month,		
	la send		Moutre The Will MD OCME			MAY 8, 200	)5	
	1 ck sou	- 4	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  71.5 (1/5)	eet Ral	timore	Mozer 1 1	21.201	1.6
	Sta	. 3	31. Date filed (Month, Day, Tear)	cer Dal	rtiiote	, rary tand	<del>∠1201</del>	
	Registr	ar	MAY 1 2 2005 de le 18 19 19 19 19 19 19 19 19 19 19 19 19 19					

			For State Registrar	State of N	Maryland / D	epartmen Certificat			F	Reg. No.2 0 0	5 16083
	Physicia	an	1. Decedent's Name (First, Middle		ietta Ch	ority I	Jarria		2. Date of Dea Month	Day Ye	M
	/Medic Examin		4a. Facility Name (If not institution					cation of Death		4c. County of [	
	<u> </u>		4315 Norfolk	Avenue		Bal				Balto	
	Funeral Director		5. Social Security Number 223-44-9843	6. Sex 7. / 1 ☐ M 2 ☒ F	Age (In yrs. last birt	hday) If Under Months Yrs.		Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day 2 2	/, Year)	Birthplace (State or Foreign Country)  Va
	land		Usual Residence of Decedent  10a. State 10b. County		10c. City, Towr	or Location					10d. Inside City Limits
	Mary -1 sh	to	Md	N/A	Ba1	to					1X1Yes 2□No
	th tha	Director	10e. Street and Number			10f. Zip	Code			10g. Citizen of Wha	t Country?
	ath wi	ra [	4315 Norfolk A				21216			USA	A
36	within 72 hours after death with the Maryland liene. Item *neture!; or Items 23e or 28e-f show the "Neclical Examble or Instituted at the Medical Examble or Instituted at the Institute at the Inst	by Funeral	11. Marital Status  1 □ Never Married 2 □ Marriad  3 ☒ Widowed 4 □ Divorced	If Vac Giva	s? Z No	13. Was Dece	cify Cuban, N	anic Origin? (S Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)		American Indian, White, etc. Black
Ö	thour	ed b	15. Deceden	nt's Education		Decedent's Usu	al Occupation	n ,		16b. Kind of Busin	ess/Industry
21215	filed within 72 Hygiene. other then "ne ent, the Medic	Completed	(Specify only highe Elementary/Secondary (0-12) Unl	st grade completed) College (1-4c	or 5+) Unk	(Give kind of wo life. DO NOT u Domes	erk done durir se retired) stic W		King	Private	Homes
	be filed at othe event,	To Be C	17. Father's Name (First, Middle, John Sweeny	Last)	·		18		ne (First, Middle, ne Steve:	Maiden Surname)	
ary	and s m		19a. Informant's Name/Relations			-				ar, City or Town, Sta	
	Health Health tem 27 I		Esther Harris	- Daughter		24 N. Ke		Avenue	Balt	o, Md 20c. Location - Cit	21205
Baltimore,	Pages 1 au nent of Hea ent: If Item ury or othe		20a. Method of Disposition  **Burial 2 Cremation	3 Removal from Sta	ile	Disposition (Nat y, crematory or o		1			
Ιŧπ	permit, Pages Department of Importent: If I eny injury or once	li	4 □Donation 5 □ Other (S		Crossr	oad Bapt			1-2005 1arch F/	South Bo H West	ston, va
Ba	permit, Departr Importe eny inju		brit	to K. S	med					to, Md 21	215
			23a. Part1. Enter the disease, o shock, or heart failure. List	r complications that can't only one cause on each	sed the death. Do	not enter the mod	de of dying, s	such as cardiad	or respiratory ar	rest,	Approximate Interval Between
	Priysician	0 1	Immediate Cause (Final disease or condition	A 1	ETASTAT	ric A:	DENO	CARCIA	UCM A	LUNG	Onset and Death Month;
	/Medical Examiner		resulting in death)		as a consequence						
	sit ad	iner	Sequentially list conditions, if any, leading to him adiabacause. Enter Underlying	b. Due to (or	as a consequence	of]-				+	
V	death certificate ba executad e attending physician and of for use as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or	as a consequence	of):					
3760,	ate ba hysicia ihe bur	cal		d							
89 x	leath certificat attending phy I for use as th	/Mec	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		_	X			23d. Date of	f delivery
.O. Box	that the death ed by the atter detached for u	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		n 2 □ Fetal death t at time of death n	3 □Ectopic p 5 □ Other (s)				Month	Day Year
s, P	ras that the igned by be detact	by Ph	Part II. Other significant condition	ions contributing to deat	h but not resulting i	n the underlying	cause given i	in Part I.			ite to the cause of death?
ord	w requir been si should	ted									
Record	The lay ate has page 2	Completed								osy prio rmed? dea	re autopsy findings available r to completion of cause of th? Yes 2 \sum No
Vital	Physician: this certificated ral director,	Be	25. Was case referred to medical examiner?	Hospital:			Othor		ath (Check only o		
of	Physi this c	. To	1 ☐ Yes 2 ☐ No  27. Manner of Death	28a. Date of			The car			dence 6 Other of the following occurred	(Specify)
	ding h. After funer	tlon	1 ☑Natural 5 ☐ Pendi	(Adamsh		Injury M	28c. Injury at Work? 1 □ Yes	s 2 □No		, ,	
Division	l or Attending after death. Director: After	Certification:	3 Suicide 6 ☐ Could	mined 286. Place of	Injury - At home, fa , etc. (Specify)	arm, street, factor	ry, office		28f. Location (S City of To	Street and Number ( wn, State)	or Rural Route Number,
_	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the t	edical Co	29a. Certifier 1 Certify (Check only 2 Medica	ing Physician: To the bas I Examiner: On the bas and manne	is of examination ar	e, death occurred nd/or investigation	at the time, n, in my opini	date and place ion, death occi	a, and due to the urred at the time,	cause(s) and mann date and place, and	er as stated. I due to the cause(s)
	To the within 2 To the complei	Me	29b. Signature and title of certific	/	(		DC. License n			29d. Date signed (/	Month, Day, Year)
	2		30. Name and a Tress of person		of death (Item 23a)	(Type, Print)				MAY 1	12005
	'8		M. VASAN			1. N.	DUTHU	12 V2 W	# 407	MDZ	1201
	St Regist	ate rar	31. Date filed (Month, Day, Yea.	2 2005 32. Rec	gistrar's Signature	book	<u> </u>				

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 16084 Certificate of Death Rea. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Vear **Physician** Ma 0550 2005 Joseph Arthur Harkum, Sr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** ANNE ARUNDEL HOSPITAL GLEN BURNIE NORTH ARUNDEL If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sax **Funeral** Months Days Hours 1 M M 2 □ F 1933 215-30-7084 71 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County rel', or Items 23e or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director MD Anne Arundel Pasadena 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21122 U.S.A. 8434 Garden Road Funeral 12. Was Decedent Ever in U.S.
Armed Forces?

12 Yes 2 No 1959If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: ģ Year or Dates: 1962 White 3 Widowed 4 Divorced "neturel" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 7 is marked other than "neture traumatic event, the Wedical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Hygiene Automobile 12 Salesman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mental Cresenthia Teresa Yesker Arthur Evans Harkum 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a Importent: If item 27 is eny injury or other trei once. 8434 Garden Road, Pasadena, MD 21122 Kathy Harkum / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 05/14/05 Baltimore, MD `4 ☐ Donation 5 ☐ Other (Specify) Holy Cross Cem 22. Name and Address of Facility G.J.Gonce Funeral Home, PA 21. Signature of Funeral Service Licensee 169 Riviera Drive, Pasadena, MD 21122 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death OBSTRUCTIVE CHRONIC STATE Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner fany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical as the l IF FEMALE If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Dav in the past 12 months?
1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, q 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 Yes 2 No certificate Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: 4 Nursing Home Hospital: 1 Inpatient 2 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 1 🗌 Yes this Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No after death Director: 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical completely and manner stated within 2 29c. License number 29d. Date signed (Month Day, Year) 29b. Signature and title of certifier DO060824 HUSPIAN GLENBURME 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NNENNA I OKIGBO, MD, NORTH ARUNDEL . Registrar's Signature 31. Date filed (Month, Day, Year) State MAY 1 2 2005 Registrar

DHMH 17 Rev 1/2001

HARKUM,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** May 2005 10 10:21 AM Kathleen M. Houston /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford 10 Lockhart Circle Forest Hill | It Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or For Nov. 15, 1923 | Pennsylvania Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** 1 ☐ M 2 ☐ F Yrs. 186-14-2260 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ " any injury or other traumatic even." 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 ☐ No Directo Forest Hill Maryland Harkord 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10 Lockhart Circle 21050 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) I □Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: White Specify: Be Completed by 3 ☑ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12th Grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edwina Kerchoff James McCullough 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mrs. Nancy Bredder 2008 Churchhill Downs Ct., Forest Hill, MD 21050 (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 X Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Anthony Cemetery 5/14/2005 Lancaster, PA 21. Signatury of Pyneral Service Licensee 22. Name and Address of Facility Schimunek Funeral Homes 9705 Belair Rd., Baltimore, MD 21236 23a. Part. Enter ne diseas, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or an failure. List only one cause on each line. Approximate Interval Between Immediate Ca e (Fina disease or countion resulting in death) Prosician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Be Completed by Physician/Medical Examiner Hospital or Attanding Physician: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. the attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Day Year 5 Other (specify) ate has been signed by the a page 2 should be detached f 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 \( \subseteq \text{ Yes} \quad 2 \subseteq \text{ No} \) 24a. Was an autopsy performed? Yes 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Assidence 6 Other (Specify) 1 Yes 2 No Hospital: ٩ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident after death Diractor: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funaral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) Signature and title a certific 29c. License number 29d. Date signed (Month, Day, Year) 100 of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

10

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

			For State Registrar	State of Marylan		ment of H			iene	05	15086
			Decedent's Name (First, Middle, Last	)				2. Date of Dea Month		Year	3. Time of Death
	Physicia /Medic		Carrie		Jenn			Month 5		005 <sup>ear</sup>	7:15a <sup>M</sup>
	Examin		4a. Facility Name (If not institution, give 4638 Marble Hal	1 Road		Ва	Location of Death ltimore			y of Deeth NA	
ł	Funeral Director		41 1-47-3114	X 7. Age (In yrs.		Under 1 Year onths Days	tf Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day C Z ~ 2	Year) 1-24	9. Birthp Coun	lace (State or Foreign try) Tenn.
	Maryland	ctor	Usual Residence of Decedent  10a. State 10b. County    10b. County   10b	10c. Cit	y, Town or Location	on 1012				1	0d. tnside City Limits  1 Yes 2 □ No
	h with the	Funeral Director	10e. Street and Number 4638 MA	eble Hall P	4	10f. Zip Code Z 1	239	1	0g. Citizen of	What Coun	try?
36	s 1 and 2 should be filed within 72 hours after deeth with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, Ita Madical Examinat main be notified at	by Funer	11. Marital Status  1 Never Married 2 Married  3 Midowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Decedent of Hi es, specify Cuba Yes 2 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		ice - Americack, White,	
215-0036	within 72 houene.	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)		(Give kind life, DO		during most of work )	ing	16b. Kind of I		
121	be filed w tal Hygier d other the		17. Father's Name (First, Middle, Last)		nous	sekeepin	18. Mother's Nam	e (First, Middle,	J.H. Maiden Suma		rsity
Maryland	should be find Mental Harked of	To Be	QuILL FR	eeman			Ella		D	avis	0.41
Mar	d 2 sho th and 7 is m traum		19a. Informant's Name/Relationship (7		19b. Mailing A	10000	and Number or Rur Rble   Al				MD 21239
	s 1 and 2 f Health Item 27 other tra		LCRENZO Jej  20a. Method of Disposition	* 20b. F	Place of Disposition	n (Name of		Date	20c. Location		
e E	Pages nent of int: If it		1 🛱 8urial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Specify	Hemoval from State	uid Rida			105	Battin	ore, 1	ND
Baltimore,	permit. Page Depertment o Important: If any injury or once.		21. Signature of Sone ral Service Licens	the.			'.H. East	11	timore Ol E.		21202 Ave.
	Pnysician /Medical		23a Part 1. Enter the disease, or compositions, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a.  Due o (or as a consequence)	70		g, such as cardiac	or respiratory arr	est,		Approximate Interval Between Onset and Death Months
760,	te be executed ysicien and be burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of High) that initiated events resulting in death) Last	b. Due to for as a conseq c. Due to (or as a conseq d		l ti	CINTV				4 years
.O. Box 68	that the death certificate be execu ed by the attending physicien and detached for use as the burial-tra	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	Ideath 3⊡Ec	topic pregnancy her <i>(specify)</i>				ate of delive	ory Day Year
<u>α</u>	S 00	d by Ph	Part tt. Other significant conditions co	ontributing to death but not res	ulting in the unde	rlying cause give	en in Part I.	23e. Did to	1		ne cause of death?
Records,	e law has b	omplete						24a. Was a autop: perfor	sy	prior to cor death?	psy findings available inpletion of cause of
Vital	ysician: The is certificate director, pag	Bec	25. Was case referred to medical examiner?				26. Place of Deat	h (Check only or	10)		
Division of V	ing Phys n. After this funeral di	2	1 Yes 2 No  27. Manner of Teath 1 Natural 5 Pending 2 Accident investigation	28a. Date of tnjury (Month, Day Year)	28b. Time of tnjury	3 DOA Other	y at	28d. Describe h			y)
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	e Hospital 124 hours a e Funerel i letely filled	Medical C		ysician: To the best of my kno niner: On the basis of examina and manner stated.							
	within To the	Me	29b. Signature and title of certifier			29c. License	e number	2	9d. Date sign	ed (Month,	Dey, Year)
			My w	ID,		VO	55059		5/	6,0	2005
_	1		7	completed cause of death (Item	m 23a) (Type, Prii Memor	ial H	ospital,	3333. N	Calv	est Str	Doy, Year) 2005  est Biltmi
1	Sta Regist	ate rar	31. Date filed (Month, Day, Year) MAY 1 2 2	32 registrar's Signal	ture for	W	-				<i>7111</i> , 0

		-	State of Maryland / Department of Health  State of Maryland / Department of Health  Certificate of Death		giene Reg. No. 005	6087
ı	Physicia		1. Decedent's Name (First, Middle, Last)  TCAACT. JONES	2. Date of Dea Month	Day Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location		4c. County of Deeth	1 4 0 00 .
			Mercy Hospital  5. Social Security Number  6. Sex., 7. Age (In yrs. last birthday) If Under 1 Year If Under	re r24 Hrs. 8. Date of Birth	n/a	polace (State or Foreign
Į,	Funeral Director		2/0-0/-052/ 1/2M 2 F S Yrs. Months Days Hours Usual Residence of Decedent	Min. (Month, Day	TIGIG Co.	nplace (State or Foreign USA
	filed within 72 hours after death with the Maryland Hygiene. Hygiene, sthan "naturelt, or items 23a or 28a-f show after than "naturelt, or itemized all ent, the Modical Examinar must be indifficed all	-	10a. State 10b. County 10c. City, Town or Location Baltimore			10d. Inside City Limits 1 ☐ Yes 2 No
	28a-f	recto	10e. Street and Number 10f. Zip Code		10g. Citizen of What Co	
	th with	al Di	925 WOODLYNN ROAD 21221		USA	
	ter dea	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 1 Married 1 Never Married 2 Married 1 Never Mar	rigin? (Specify Yes or No- an, Puerto Rican, etc.)	14. Race - Amei Black, White	
5-0036	ours aft	þ	3 □ Widowed 4 □ Divorced	r.	Specify:Whi	te
- - -	n 72 ho "natur	letec	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during mo (file. DO NOT use retired)	st of working	16b. Kind of Business/I	
212	d withi	Completed	Elementary/Secondary (0-12) College (1-4or 5+) Mail Clerk		Post Offi	.ce
$\sqsubseteq$	e d ta b	Be		ner's Name (First, Middle, rtha Neal	Maiden Sumame)	
ary	should land Menis marka	၉	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Numb	ber or Rural Route Numbe	r, City or Town, State, Z	ip Code)
	Health a tem 27 is		Elfrieda Jones /wife 925 WoodLynn R  20a. Method of Disposition 20b. Place of Disposition (Name of		20c. Location - City or 1	Four State
altimore,	Pages nent of h int: If ite iry or of		1 Burial 2XCremation 3 Removal from State 4 Donation 5 Other (Specify)  1 Bury iewCrematory		Baltimore	
Baltii	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marka any injury or othar traumatic.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Connection 300 Mace A	Commercy		meofEssex
			23a. Part 1. Enter the disease, or complications that caused the death. To not enter the mode of dying, such as shock, or heart failure. List only one cause on each line.			Approximate Interval Between Onset and Death
1	Physician /Medical	1	Immediate Cause (Final disease or condition resulting in death)  a. Due to ()r as a consequence of):	AMOUL		Onsot and Dodg.
8	Examiner		Sequentially list conditions			
7	ted nsit	Examiner	Cause (Disease or injury			
o O	ate be executed hysician and the burial-transit	Exar	that initiated events resulting in death) Last Due to (or as a consequence of):			
68760,	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dical	d			
Box	eath certifica attending pl	an/Me	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of deli	· ·
о. В	that the dea led by the att detached fo	Physician/M	in the past 12 months?  1   Yes   2   No   9   Unknown   9   Unknown   1   1   1   1   1   1   1   1   1		Month	Day Year
ري ح	res that tigned by	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part	I. 23e. Did to	obacco use contribute to	the cause of death?
ord	w require been sig should b			1 □ Y		obably 4 Unknown
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Viital	stan: T	BeC	examiner?	1 ☐ Yes ce of Death (Check only or		2 No
	Attanding Physician: r death. ector: After this certifics by the funeral director,	2	1 Yes 2 No Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 No 27, Manner of Death 28a, Date of Injury 28b, Time of 28c, Injury at	lursing Home 5 Resid	dence 6 Other (Spec	ify)
ion	ttanding F death. ctor: After / the funer	atlor	1 Natural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation M 1 Yes 2 □	]No		
Division of	f or Attand after death Director: I in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S City or Tow	Street and Number or Rus n, State)	ral Route Number,
_	To the Hospital or Attanding Physician: The wilhin 24 hours after death.  To the Funeral Director: Atter this certificate h completely filled in by the funeral director, page		29a. Certifier  (Check only   Certifying Physician: To the best of my knowledge, death occurred at the time, date a control of the basis of examination and/or investigation, in my opinion, de			
	thin 24 thin 24 the Fi	Medical	one)  and manner stated.  29b. Signature and title of certifier  WCDCAL DACTOR  29c. License number		29d. Date signed (Month	
)	Z × Z		TECHNIZA PRATEIN PISSE	30	0511010	5
	10		30. Name and a dre is of person who completed cause of death (Item 23a) (Type; Print)	~ MM -	71771	_
	Sta	te	31. Date filed (Month, Day, Year) MAY 1 2 2005  32. Pigistrar's Signature	(C) 100	21001	
3,0	Registr		MAY 1 2 2005 Steen & Specker			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** EANOR 04 7:45 AM 2005 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner CHRIS" If Under 1 Year Date of Birth (Month, Day 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace Country) **Funeral** 1□M 2₽F Months Days Hours Min. 217-48-2016 Yrs. Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic evant, the Medical Examinar must be notified at 1 res 2 No Director 10e. Street and Number 10g. Citizen of What Country? JITED 2 should be filed within 72 hours after death a and Mental Hygiene. Is marked othar than "natural", or Items 23 Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: U Specify: HITE þ 3 ☐ Widowed 4 Proivorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) BARMAII 19 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be MHOG MERRYMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Date 20c. Location - City or Town, State Department of Health Important: If item 27 DOROTHY CARTER/DAUGHTER 825 SHAWAN RD.C 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State \* 4 Donation 5 ☐ Other (Specify) ANATOMY GIFTS KEGI 21. Signatur of Fun 22. Name and Address of Facility any ir Daugherty Family Funeral Home And Cremation Center, P.A. 2601 Mountain Road - Pasadena, MD. 21122 Approximate Interval Between Onset and Death or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. shock, or heart failure. Immediate Cause (Final 6/106/astoma Multitorine Pnysician Months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cauce. Entire Underlying Cause (Disease or injury Due to (or as a consequence of): Examine that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 1 Tyes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No 1 🗌 Yes 1 TYes 2 🗆 No Division of Vital To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 TYes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: After 1 Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after deatl To the Funeral Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

L Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

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31. Date filed (Month, Day, Year)

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician**  $\mathbf{P}^{\mathsf{M}}$ JOSEPH C. LEWIS APRIL 30 2005 9:20 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4420 MAIN STREET GRASONVILLE QUEEN ANNE'S If Under 24 Hrs. Hours Min. If Under 1 Year Months Days 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** 1**∑**M 2□F MARYLAND FEB. 7, 1931 Director 214-28-7979 Usual Residence of Decedent Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Items 23a or 28a-f show of Health and Mental Hygiene. If Item 27 is marked other then "natural", or Items 23s or 28s-1 show or other treumatic event, the Modical Examiner must be notified at 1 Tes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10 d Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Specify: WHITE Baltimore, Maryland 21215-0036 1 Yes 2 No If Yes, Give Year or Dates: Specify: þ 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be FRANKLIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MAIN Date 20 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 20c. Location - City or Town, State or other place; 1 Burial 2 Cremation 3 Removal from State = 5 Department of Importent: If eny injury or one GIFTS REG 4 Donation 5 Other (Specify) permit. 21. Signatur 22. Name and Address of Facility Daugherty Family Funeral Home And Cremation Center, P.A. 2601 Mountain Road - Pasadena, MD. 21122 23a. Part 1. Enter the disease of complications that ensed the shock, or heart failure. List only one cause on each line. Beath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death mmediate Cause (Final onth Physician disease or condition resulting in death) 01 /Medical Due to (or as a consequence of): **Examiner** Satuentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Que to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): .O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown signed by the Division of Vital Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably been si Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s certificete 1 Yes 2 No To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☐ No 4 Nursing Home 5 Residence 6 ☐ Other (Specify) ٩ this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Medical Certification; After 1-Natural 5 Pending investigation Injury 2 No death. 1 Tyes 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00055035 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) och Raven Blee 3900 Baltimo 31. Date Hed (Month, Day, Year) 32. P State 12 Registrar

		1 - For State Registrar	State of Maryla	-	artmen <i>rtificate</i>					giene	005	16090
Physic	oian	Decedent's Name (First, Middle, Last)							2. Date of Dea	ath Day	Year	3. Time of Death
/Med		Edward Jos	-	s	T				May 6,	2005		7:15 P M
Exam	iner	4a. Facility Name (If not institution, give s 3105 Ady Road	treet and number)				Location of	of Death			ity of Death	
Funera		5. Social Security Number 6. Sex	7. Age (In yrs	s. last birthday,	If Under	tree	If Under	24 Hrs.	8. Date of Birt		larfor	
Directo			MM 2□F	91 Yrs.	Months	Days	Hours	Min.	8. Date of Birt (Month, Day Feb. 2		Mai	place (State or Foreign intry) n⊖
pu *		Usual Residence of Decedent  10a. State 10b. County	100.0	ity, Town or L	anting.							10d. Inside City Limits
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tha 1	Funeral Directo	Maryland Harford  10e. Street and Number	<u>a</u>	Stree	10f. Zip	Code				10g. Citizen o	f What Cou	intry?
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72 hours after death with tha Maryland 72 hours after death with tha Maryland neture!', or items 23e or 28e-f show sizel Evant at must be rotified at		3 🔀 Widowed 4 □ Divorced  15. Decedent's Educ	Year or Dates:	163 Dece	dent's Usua	Occupa	tion					White
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ba file tal Hy od oth	Be (	17. Father's Name (First, Middle, Last)					18. Mothe	er's Name	(First, Middle,			
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ages ent of nt: If it		1 ☑ Burial 2 ☐ Cremation 3 ☑R. 14 ☐ Donation 5 ☑ Other (Specify)	emoval from State	cemetery, cre orinth	,		1	. 5	_14_05		•	
permit. Pages Department of Important: If it eny injury or once.		21. Signatur / 5 new Service Licence	99	2:	2. Name an	d Address	s of Facilit	lv			OT MI	lson, VA
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od dansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events										
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Attending at death. actor: Afte by the fune	ifica	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At I	nome, farm, str	eet, factory	office		2			ber or Rura	al Route Number,
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To the Hospitel or Attending Physicien: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical (	29a. Certifier (Check only one) Certifying Phys	ician: To the best of my kn er: On the basis of examin and manner stated.	owledge, deat ation and/or in	h occurred a vestigation,	it the time in my opi	a, date and nion, deat	d place, a th occurre	and due to the co	ause(s) and m late and place	nanner as si , and due to	tated. the cause(s)
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Si Regis	tate trar	31. Date filed (Month, Day, Year) MAY 12 20	05 Seam	15 19	oste							Day, Year)  2005  INT M D  21239

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 11:25 PM Lastowski Catherine Z. May 10. 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore

If Under 1 Year If Under 24 Hrs. 8. Date of Birth

Months Days Hours Min. Jan. 16, 1909 Pennsylvania 9503 Gunview Road 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign 5. Social Security Number **Funeral** 1 ☐ M 2 🙀 F Yrs 189-01-9862 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ortant: If item 27 ie marked other than "naturel", or Items 23a or 28a-1 ehov Injury or other traumatic event, the Madical Examinar must be notfilled at Baltimore 1 Yes 2 No Maryland Baltimore Director with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21236 u.s.A. 9503 Gunview Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💆 No Specify: Specify: White δ 3 \ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene Important: If item 27 ie marked other than "ns any injury or other traumatic event, The Media 0003. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home. 12th Grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mathias Zaledonis Maru Keaolis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Patricia Cowan (daughter) 9503 Gunview Road. Baltimore. MD 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 5/14/2005 Baltimore, Maryland Oak Lawn Cemeteru ' 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of Funeral Service Licensee 9705 Belair Rd., Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner that the death certificate be executed the attending physicien and ned for use as the burial-transit Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? page 2 should be detached for Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, γq 1 ☐ Yes 2 🔀 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No this certificate has 1 ☐ Yes To the Hospital or Attending Physicien: within 24 hours after death.
To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pendina 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 29a. Certifier l 🛣 Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and file of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

10

ORIGINAL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Palistrar's Signature

100

			For State Registrar	State of Maryla	-	artment of rtificate o		nd Mer	-	ene . No 2 0 0	5 16092
	Physici	an	1. Decedent's Name (First, Middle, Las	Leblina					Date of Death Month	Day / Ye	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)	Lake	4b. City, Town	or Location of	Death	31	4c. County of E	
	Funeral Director		5. Social Security Number 577-32-9084 6. Si		rs. last birthday) Yrs.	If Under 1 Year Months Day		Min. De	Date of Birth (Month, Day, Y ec 2, 1	<sup>(ear)</sup> 928 Wa	Birthplace (State or Foreign Country) ashington DC
	show	۰	Usual Residence of Decedent		City, Town or Lo						10d. Inside City Limits 1 ☐ Yes 2 No
	r 28a-f	Funeral Director	10e. Street and Number	rei	Ocean	10f. Zip Code	)		100	. Citizen of Wha	
	ath with	ralD	5 Willow Way				21811			USA	
336	urs after dealing or terme		11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces?  1 XYes 2 □ No If Yes, Give Year or Dates: 5		Was Decedent of If Yes, specify Control of Yes 2 № N		in? (Specify , Puerto Rica	Yes or No- an, etc.)	Black, V	American India <i>n</i> , White, etc. White
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel', or iteme 23a or 28a-f show appringury or other traumatic event, I're Madical Exarting regal by Incilliant at ODGe.	Completed by	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12) 1 2	ducation	16a. Dece	dent's Usual Occ kind of work dor DO NOT use reti	ne durina most	of working	arric	b. Kind of Busin	
Maryland 2	uld be filed v fental Hygie rked other i tic event, II	To Be Co	17. Father's Name (First, Middle, Last) Howard Victor Mo					's Name <i>(Fi</i>		uiden Sumame)	
Mary	12 should have and have rise maintains		19a. Informant's Name/Relationship (							City or Town, Sta	te, Zip Code)
altimore, I	Pages 1 and ent of Healtl nt: If item 27 ry or other 1		Bonney Lebling/s  20a. Method of Disposition  1 Burial 2 Cremation 3 4 Donation 5 Other (Specify	Removal from State	. Place of Dispo	110W Way psition (Name of matory or other p		Pines		21811 c. Location - City	y or Town, State
Balti	permit. Departm Importe eny inju		Sminn	Wade, Direct	В.	altimore	MD C	21201			re Street
ļ,			23a. Part 1. Enter the disease, or company shock, of heart failure. List only Immediate Cause (Final	plications that caused the do one cause on each line.	eath. Do not en	ter the mode of d	ying, such as o	cardiac or re	spiratory arres	t,	Approximate Interval Between Onset and Death
	/Medical Examiner	_	disease or condition resulting in death)	b. Due to (or as a cons		opher	V (	an			1/240000
·00	death certificate be executed e attending physician and of for use as the burial-transit	I Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a cons							
68760,	ficate by physicas the b	edlca		_ d						1	
.O. Box	he death certific the attending p thed for use as i	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pre 1 Live birth 2 F 4 Pregnant at time of 9 Unknown	etal death 3	□Ectopic pregnal □ Other (specify)				23d. Date of Month	,
Δ.	iaw requires that the de as been signed by the a 2 should be detached t	by	Part II. Other significant conditions of	contributing to death but not	resulting in the u	inderlying cause	given in Part I.		23e. Did toba		ite to the cause of death?  Probably 4 □Unknown
Vital Records,	The ate h	Completed						_	24a. Was an autopsy performe	prior pd? deat	re autopsy findings available r to completion of cause of th? Yes No
Vita	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner? 1 ☐ Yes No	Hospital. Inpatient 2	. □ ER/Outpatie	3 7004	)thor		heck only one)	ce 6 Other (	(Specify)
ion of	ding After fune	atlon; To	27. Manner Death Anatural 5 Pending 2 Accident investigation	28a. Late of Injury (Month, Day Year	28b. Time o	f 28c. In		28d.		injury occurred	<i>Эрвспу)</i>
Division	tal or Attenders after death	Certification;	3 Suicide 6 Could not be 4 Homicide determined		t home, farm, st ecify)	reet, factory, offic	ce .	28f.	Location (Stre City or Town,		or Rural Route Number,
	To the Hospital within 24 hours a To the Funeral Completely filled	edical	(Check only one) Medical Exam	nysician: To the best of my loniner: On the basis of exam and manner stated.					at the time, dat	e and place, and	due to the cause(s)
)	To 1 To 1	Z	29b. Signature and title of certifier	61	nn	29c. Lice	36	27	290	J. Date signed (M	Month, Day, Year) 4-05
			30. Name and address of person who	completed cause of death (	tem 23a) (Type,	Print)	POI	3×1	732	Calif	111 2/802
	Sta Regist		31. Date filed (MAY) Pay Year) 20	2. Registrar's Si	gnature	els.				C	)

			1 - For State Registrer	State of Mary		artment of I			ene 2005	5 1509
	Physic /Medi		1. Decedent's Name (First, Middle, Last) Lloyd W. Mead					2. Date of Death May 9	Day 2005 Year	3. Time of Death 4:30p <sub>M</sub>
	Exami	ner	4a. Facility Name (If not institution, give s 439A K1ee Mill Roa			4b. City, Town, C Sykesvi	r Location of Death	h	4c. County of Death Carroll	
	Funeral Director		5. Social Security Number 6. Sex 235–56–9805	7. Age (In 67	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, ) Feb 22 1	9. Birthy Cour 938 WV	place (State or Foreign ntry)
	Maryland -f show	tor	10a. State 10b. County Md Carroll		City, Town or Lo					0d. Inside City Limits 1 ☐ Yes 2 ☐ No
	h with the 23a or 28a at be noti	Funeral Director	10e. Street and Number 439A Klee Mill R	Road		10f. Zip Code 21784		US.	g. Citizen of What Cour A	ntry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic event, Ire Medical Exempre injuried at ance.	þ	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 💢 Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cub	dispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Americ Black, White, Specify: Whit	etc.
Baltimore, Maryland 21215-0036	id within 72 ho giene. er than "natu	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12	cation completed) College (1-4or 5+)		dent's Usual Occup kind of work done DO NOT use retire Arehouse	oation during most of wor d) worker	king 16	warehousing	,
yland	ould be file Mental Hy arkad oth	To Be (	17. Father's Name (First, Middle, Last) Samuel Meadows					ne <i>(First, Middle, Ma</i> Gillspie	iden Sumame)	
, Mar	and 2 sho salth and n 27 is mu er traums		19a. Informant's Name/Relationship (Type Lisa Meadows (daugh		19b. Mailin 604 (	g Address <i>(Street</i> Concord I	and Number or Ru ane, Syk	ral Route Number, C esville, 1	City or Town, State, Zip Md 21784	Code)
imore	Pages 1 nent of He ant: If itan ury or oth		20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Re 1 ☐ Donation 5 ☐ Other (Specify)	emoval from State		natory or other plac	ion 5-13		c. Location - City or Toy ${\sf ykesville}$ ,	
Balt	permit. Depart Import any inj		21. Signature of Funeral Service License	Hailt	P.	0. Box 1	95 Sykes	ville, Mo	ral Home & d 21784	Chapel
1	Pnysician /Medical		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	cations that called the decause on each line.  COT  Due to (or as a con	D	er the mode of dyin	ig, such as cardiac	or respiratory arrest		Approximate Interval Between Onset and Death
8760,	ate be executed with the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lister of the Cause) that initiated events resulting in death) Last	Due to (or as a con-						
O. Box 6	death certificate e attending phy: id for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	3c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time of 9 □ Unknown	etal death 3 🗌	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ry Day Year
rds, P	quires that in signed t	by	Part II. Other significant conditions cont  Hypertensia		resulting in the un	derlying cause giv	en in Part I.		co use contribute to th	
Vital Records,	The faw requires that the rate has been signed by the page 2 should be detache	Completed	Dyshpidem		Failure			24a. Was an autopsy performed	prior to con death?	osy findings available appletion of cause of
_	hysician: this certifica al director, p	To Be	25. Was case referred to medical examiner?	asnital:	≥ ☐ ER/Outpatient	28c. Injun Worl	er: 4 🗆 Nursing Ho	th (Check only one) ome 5 Residence 28d. Describe how	e 6 ∏Other (Specify	22 No
DIVISION	ital or Attanding F rs after death. al Director: After i ed in by the funera	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, stre	et, factory, office		28f. Location (Stree City or Town, S	t and Number or Rural State)	Route Number,
	To tha Hospital of within 24 hours af To tha Funaral D completely filled in	edical	one)	cian: To the best of my l er: On the basis of exam and manner stated.	knowledge, death ination and/or inve	occurred at the timestigation, in my of	ne, date and place, pinion, death occur	and due to the caus red at the time, date	e(s) and manner as sta and place, and due to	ited. the cause(s)
	with To I	Σ	29b. Signature and title of certifier  MKM			29c. License	186		Date signed (Month, D	Pay, Year)
	10		30. Name and address of person who com	npleted cause of death (I 3 80 PROG 32. Registrar's Sig	RESS W	Ay EU	erskul	2178	4	
E E	Sta Registr		31. Date filed (Month, Day, Year)  MAY 1 2 2005	32. Registrar's Sig	gnature	,				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MONTH IL Day ZI **Physician** YEAR ! 2:35 FM Albert Moore /Medical 4c. County of Death imore 4a. Facility Name (If not institution give street and number) 4b. City, Town, or Location of Death Examiner Center If Under 1 Year | If Under 24 Hrs. 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Apr 23, 1929 Birthplace (State or Foreign Country) Days 1X M 2□ F unk 215-28-7574 76 Director Usual Residence of Decedent death with the Maryland 10a State 10h Counts 10c. City, Town or Location item 27 is marked other then "naturel", or Items 23a or 28a-f ehow other treumatic event, the Medical Examinar must be notified at 10d. Inside City Limits MD Baltimore Director Baltimore 1 ☐ Yes 27 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 700 York Road 21204 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Introduction: If tiem 21 is marked other then "nature!, or lier any injury or other treumatic event. Black, White, etc 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ Specify: white 3 Widowed 4 NDivorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry unk unk Elementary/Secondary (0-12) College (1-4or 5+) unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) St. Joseph Medical Cen ter 7601 Osler Drive Towson, MD 21204 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State `4 □Donation 5 🕅 Other (Specify) in state 21. Signal are of superal Service icensee Wade State Anatomy Board 655 W. Baltimore Street baltimore, MD 21201 mon 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death SEVERE INTERSTITIAL LUNG DISEASE Priysician /Medical Due to (or as a consequence of): RIGHT FNEUMOTHORAX **Examiner** Esquentially flat conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of): physician Box 68760 Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death Month Day Year 5 Other (specify) P.0. the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2500 24a. Was an page 2 autopsy performed? certificate l 1 Yes 25 No the Hospitel or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 1 No Linpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. injury at Work? 28b. Time of 28d. Describe how injury occurred Atter Certification: 1<del>c⊠</del>Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel D Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 lella D41410 30. Name an add s of person who completed cause of death (Item 23a) (Type, Print) JOGINDER P. MEHTA, M. D. 7601 OSLER DRIVE, TOWSON, MARYLAND 21204 31. Date filed (Month, Day, Year) 32 Registrar's Signature State MAY 1 2 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend Item II per fh 8843 5-I2-05 vt
State of Maryland / Department of Health and Mental Hygiene 1 - State Registral Certificate of Death Reg. No. U 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day O3 Month **Physician** MARUIN ELLSWORTH MILLER 4:00 PM 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HARBOR HOSPITAL CENTER BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day.

JUNE 21 5. Social Security Number 7. Age (In yrş. last birthday) Birthplace (State or Foreign Country) 6. Sex Funeral Months 1XM 20 F 97-30-2266 Director Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Modified Examilier in 181 be inclifted at once. 1⊠Yes 2□No Director MARYLAND 10g. Citizen of What Country? 10e. Street and Number 2940 Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ▼Yes 2 □ No 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 XYes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: BLACK 32 widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 THGRADE UNEMPLOYED 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be GEORGE LORENCE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2940 GARRISON BLVD BALTO, MD. 21216 JARY MARSHALL RIEND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State \*4 □ Donation 5 □ Other (Specify) SON FOREST 15-17-05 OWINGS MILLS, MA 22. Name and Address of Facility BROWN JR. FUNERAL HOME 21. Signature of Funeral Service Licensee 22. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate shock, or seart failure. List only one cause on each line. line ediate sause (Final dise to or condition resulting in death) SEPTECEMIA Pnysician /Medical **Examiner** FUNGEMIA GUILLIER MONDIN I MUSTA CCANDIDA Sequentially list conditions, if any leading to initial acause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner INFECTION or Attending Physician: The law requires that the death certificate be executed JRINARY TRACT Due to (or as a consequence of): Box 68760. VESICLE Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, SYSTOLIC HEART FAILURE 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown VANCOMYCIN RESISTANT ENTEROCOCCI 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an autopsy performed? septecemia 2 No 1 Tyes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To nours after death.

neral Director: After this filled in by the funeral di 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Kanvan Sha RESIDENT PHYSI CIAN RES 000 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE SHAFFI. 3001. S. HANOUER ST MD KAMRAN 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

MAY 1 2 2005

The law requires that the death certificate be executed Box 68760. P.0. Division of Vital Records, been signated Attanding Physician: this After

**Funeral** 

Director

item 27 is marked other than "natural", or itema 23a or 28e-1 abox other traumatic event, it as Medical Examilian must be notified at

death

filed within 72 hours after

permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Importent: If tem 27 is marked other than "na any injury or other traumatic aven?

Baltimore, Maryland 21215-0036

**Physician** /Medical **Examiner** Examine burial-tran Physician/Medical the attending pt ed by the a þ 9 e Completed certificate has birector, page 2 s Be ( Certification; To funeral 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No death. hours after death. uneral Diractor: A investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ŏ within 24 hours and To the Funeral Dir To the Hospitel 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) Mark (amo

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9 Schilling Road Hunt Valley, MD 21031 Suite 1 Mr. Mark Lamos, M.D.

9.05

State Registrar

31. Date filed (Month, Day, Year)



			1 - For State Registrar	State of Ma	aryland		artmen rtificate			ind M	- '	giene Reg. No.2	05	16097
ı	Physici		1. Decedent's Name (First, Middle, Last	Maxa							2. Date of Dea Month	Day	200 S	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give  Son Secords  5. Social Security Number 6. Se	ftegit.	(In yrs. las	A brinsh do l	_	TIMO	Location o			4c. Cou	nty of Death	, , , , , ,
	Funeral Director			XM 2□F		2 Yrs.	Months	Days	Hours	Min.	8. Date of Birt (Month, Da) JULY 1	y, Year)		place (State or Foreign otry) ARYLAND
	ath with the Maryland 8 23e or 28e-1 show	Director	10a. State 10b. County  MARYLAND N/A  10e. Street and Number		10c. City,		TIMOR					10a Ciai		10d. Inside City Limits 1 □XXXs 2 □ No
<b>'</b> 0	hours after death with the Maryland turel', or Items 23e or 28e-f show al Examinational Demonthed at	Funeral Dir	4110 FAIRFAX ROA  11. Marital Status  1 X Vever Married 2 Married	D  12. Was Decedent I Armed Forces? 1 □ Yes 2 1	Ever in U.S.	13.		2121		gin? (Spe , Puerto l	ecify Yes or No- Rican, etc.)	U.S		can Indian,
21215-0036	72	Ď	3 Widowed 4 Divorced  15. Decedent's Edu (Specify only highest grad	If Yes, Give Year or Dates:		16a. Deced	1 ☐ Yes 2 dent's Usua kind of wor	I Occupa	Specify: tion uring most	of workii	na	Spe 16b. Kind of	cify: BLA Business/In	
d 2121	filed within Hygiene. other than "	<b>Completed</b>	Elementary/Secondary (0-12) 8th grade 17. Father's Name (First, Middle, Last)	College (1-4or 5	+)	N/A	DO NOT ús	se retired)			(First, Middle.		N/A	
Maryland	should nd Mer marke umetic	To Be	CHARLES MAXEY  19a. Informant's Name/Relationship (7)	rpe, Print)	1.	19b. Mailir	ng Address		RA	CHEL	CARPEN	ITER		Code)
	1 and Health tem 27 other tr		Cleatter Marshall  20a. Method of Disposition  1 □ Burial 2X2 remation 3 □ F		20b. Plac	e of Dispo	Fair esition (Nam matory or of	ne of		Palt	inore,		and 21 in - City or To	
Baltimore,	permit. Pages Department of Importent: If ii eny injury or o		' 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licens		METI	22 W	EMATO Name and ILLIA 206 W	d Address	s of Facility BROWN	COM	MUNITY			ARYLAND E P.A.
	Physician /Medical		23a Part1. Enter the disease, or compositions, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ications that caused no cause on each lin	10.	Do not ent		e of dying				rest,		Approximate Interval Between Onset and Death
8760, <	rate be executed by sician and the burial-transit	Ical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Unease or him)	Due to (or as a Due to (or as a d.										
P.O. Box 68	death certific e attending p od for use as	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal de	eath 3	Ectopic pre			<del></del>			Date of delive	ory Day Year
	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions co	ntributing to death bu	ut not resultin	ng in the ur	nderlying ca	ause give	n in Part I.		23e. Did to			ne cause of death?
Vital Records,	The ate h page	Completed									24a. Was a autops perfor	SV	prior to cor death?	psy findings available inpletion of cause of
Division of Vita	Attending Physicien: Thir death. ector: After this certificate by the funeral director, pag	Certification: To Be	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	fospital: 1 Impatie 28a. Date of Injur (Month, Day	v 28	VOutpatien Bb. Time of Injury		A Other	r: 4□ Nur	sing Hom	Check onl, or ne 5  Reside 8d. Describe he	ence 6 🗆 C		"
Divi	or At fter o pirec in by		4 Homicide determined	28e. Place of Inju	. (Specify)						City or Town	n, State)		Route Number,
	To the Hospitel or At within 24 hours after d To the Funerel Direct completely filled in by	Medical	(Check only 2 Medical Evami											
<b>)</b>	n		29b. Signature and title of carther  30. Name and address of person who co	ompleted cause of de	eath (Item 23	Ba) (Type,	Print)	SOU	set.	<i>50</i>	05	May 0	, sa	
: 54	Sta	te	31. Date filed (Month Pax Year) 2 7[	32 Aegistra	r's Signature	1	selle	41	911/6x	15	C. 11	nirry	, mx	3
*	Registr	aı		The state of the s	- 10	1								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend item 17 per inf ed43 5-16 0 vt
State of Maryland / Department of Health and Mental Hygiene

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			1 - For State Registrar	Otato of Mi	arylaria / D	Certificate of			g. No.	10098
	Dhi.si		Decedent's Name (First, Middle, L					2. Date of Death Month		3. Time of Death
	Physici /Medio		FERRELL	MILLER				A /	6 2005	1825P M
	Examin		4a. Facility Name (If not institution, g	ive street and number)		4b. City, Town, o	r Location of Death	1	4c. County of Deat	
			1315 Cherry			Esse		.,	Baltimo	
	Funeral Director		212-20-1112	Sex 7. Ag 1 M 2 X F	e (In yrs. last birth	nday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Dec. 30,	<sup>9. Birt</sup> 1924 Wes	hplace (State or Foreign untry) tVirginia
	and		Usual Residence of Decedent 10a, State 10b, County		10c. City, Town	or Location				10d. Inside City Limits
	Aaryli F sho	ō		imore		ssex				1 ☐ Yes 2 ☐ No
	28a-	rect	10e, Street and Number			10f. Zip Code		10	g. Citizen of What Co	unto?
	3a or	Funeral Director	1315 Cherry	Garden Ro	ad	21221			USA	Jy .
	death	Jera	11. Marital Status	12. Was Decedent	Ever in U.S.	13. Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp	ecify Yes or No-	14. Race - Ame	
21215-0036	permil. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examinar must be notified at once.	by	1 ☐ Never Married 2 ☐ Married  3 ☐ Woldowed 4 ☐ Divorced	Armed Forces?  1 Yes 2 If Yes, Give Year or Dates:		If Yes, specify Cuba 1 ☐ Yes 2 🛣 No	in, Mexican, Puerto Specify:	Rican, etc.)	SpecifyWhi	
20	72 ho	eted	15. Decedent's (Specify only highest g		16a. [	Decedent's Usual Occup Give kind of work done	ation	ring 1	6b. Kind of Business/	industry
7	within ene. than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5	(4)	life. Do NoT use retired Iomemaker	1)	9	orrn ham	
	filed w Hygier sther th		8th 17. Father's Name (First, Middle, Las	·•1	F.	ollellaker	10 Mathada Mara	- /5":	own hom	e
Maryland	ntat h	Be c	Corbett Gent		entry		Ruth Ir	e (First, Middle, M พา่า	aiden Sumame)	
Ž	should ind Men in marke	P	19a. Informant's Name/Relationship		19b	Mailing Address (Street			City or Town State 2	(in Code)
<u>ω</u>	and 2 sealth ar n 27 is		Judy White /			893 Kling			hate.	
ē,	s 1 au f Hea item othe		20a. Method of Disposition		20b. Place of I	Disposition (Name of crematory or other place			Oc. Location - City or	
altimore,	II. Pages rtment of i rtant: If it njury or o		1 Surial 2 Cremation 3  '4 Donation 5 Other (Special Service Lice)	ify)		HillCemet	ery 5/1		altimore	
Ba	permit. Departr Imports any inji		N. Terr	1 (ann	elly	22. Name and Addres	ce Ave.	Baltim	roe MD 2	omeofEssex 1221
В			23a. Part1. Enter the disease, or con shock, or heart failure. List on	nolications that caused fone cause on each li	the death. De no	ot enter the mode of dyin	g, such as cardiac	or respiratory arres	st.	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a Ar Terio	sclenot	ic Cardia	vascula	er Dis	e6 se	Onset and Death
	/Medical Examiner		resulting in death)		a consequence of	The state of the s				00 0000
	LAGITITICI	Ļ	Sequentially list conditions,	b	a consequence of					
.7	led sit	nine	Sequentially list conditions, if any, learning to limitediate cause. Enter Underlying Cause (Disease or injury	Due to (or de	ar out to adjust too or	Ţ.				
V	xecui and al-trar	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a consequence of	):				
<b>68760,&lt;</b>	siciar b buris									
89	rtificate be executed ng physician and as the burial-transit	Medical		0.						
Box			IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy 2 Petal death	3 □Estania programana			23d. Date of deli	very
	that the death ce ed by the attendi detached for use	Physician/I	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at		3 ∐Ectopic pregnancy 5 ☐ Other (specify)			Month	Day Year
<u>Р</u> .	at the by the stach	Phys	9 ☐ Unknown							
	law requires that the death ce as been signed by the attendi 2 should be detached for use	ρ	Part II. Other significant conditions	contributing to death b	ut not resulting in t	he underlying cause give	en in Part I.		cco use contribute to	.,
Ö	requ been shouk	etec								
of Vital Records,	has has	Completed						24a. Was an autopsy perform	24b. Were aut prior to c death?	opsy findings available ompletion of cause of
a	ician: The certificate hi		OS Man and add a self-of-					1 ☐ Yes 2	No 1 Yes	2 <b>X</b> No
₹	sicia	o Be	25. Was case referred to medical examiner? 1 ★ Yes 2 □ No	Hospital:	- 20 FB/0.1-	Other	AC .	(Check only one,		
o	Attanding Physician: r death. ector: After this certifica by the funeral director. I	$\vdash$	27. Manner of Death	1 ☐ Inpatie	v 28b. Tir	ne of 28c. Injury		me 5 K Residen 28d. Describe how	ce 6 Other (Spec	<i>ħy)</i>
on	nding Ith. :: After	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigate	(Month, Day	/ Year) Inju		(? Yes 2 □No			
Division	Attai	Certification;	3 Suicide 6 Could not determine		ury - At home, fam	n, street, factory, office		28f. Location (Stre	et and Number or Rui	al Route Number,
ā	s afte	Cert	To more	building, etc	э. (Эрвспу)			City or Town,	Siale)	
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical	29a. Certifier 1 Certifying F (Check only one) 2 Medical Exa	hysician: To the best of iminer: On the basis of and manner sta	examination and/	death occurred at the tim or investigation, in my op	ie, date and place, pinion, death occurr	and due to the cau ed at the time, dat	se(s) and manner as e and place, and due	stated. to the cause(s)
	To th within To th	Me	29b. Signature and title of certifier			29c. License	number	290	I. Date signed (Month	Day, Year)
			Jak Miller	o MD De	Netwo	1918	667	M	ay 8.20	05
	í		30. Name and address of person who	completed cause of d	ath (Item 3a) (T	ype, Print)			ay 8, 20 lavy land	
_	10		PHILIP MILI	TELLQ, MI		mble HiLL	CTLuthe	nville 1	lary land	21093
	Sta		31. Date filed (MATA Pay 1 Year) 2	105 Aegistra	ar's Signature	Carte	•	,	l	
	Registr	-1								

			1- State Registra <b>amend ite</b> n #	2 per dvr	aryland / De g843 5 🛱				ind M		Reg. No.		16099
	Physic /Medi	cal	1. Decedent's Name (First, Middle, Last $\frac{Kevin\ L}{\text{4a. Facility Name (If not institution, give}}$	Matthews	S	Al- Cit-	Y	l and in a	6 D = 44	Mayn April	. 5 <sup>Day</sup>	2005	
	Examir	ner	Home-1209 E.Pa 5. Social Security Number 6. Se	tapsco A	Avenue 9 (In yrs. last birthda 39 Yrs.	Bal	Ltim	Ore If Under 2 Hours		8. Date of Bir (Month, Da	th		eath  Birthplace (State or Foreign Country)
	Director Mount		Usual Residence of Decedent  10a. State  10b. County		10c. City, Town or					11-5-	196	5	MD 10d. Inside City Limits
	with the Ma 3a or 28e-f a I. Le rodiffe.	Funeral Director	MD  10e. Street and Number 1209 E. Patapso	o Ave.	Balti	10f. Zip	Code 2122	5			10g. Citi	izen of What	1 XYes 2 No Country?
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Items 23a or 28e-f show empty injury or other traumatic event, the Medical Exercit er matter rediffied at once.	þ	11. Marital Status  1 Xever Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent B Armed Forces? 1 Yes 2 XN If Yes, Give Year or Dates:	Ever in U.S. 13	3. Was Deced If Yes, spec		spanic Orig n, Mexican, Specify:	in? (Spe Puerto I	cify Yes or No Rican, etc.)	-	14. Race - Ar Black, W Specify: B	
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ylaira	Schould be file and Mental Hy is marked oth sumatic event	To Be (	17. Father's Name (First, Middle, Last)  Kermit Matt  19a. informant's Name/Relationship (Ti	hews	10h Ma	ilina Addrosa		A	lice	(First, Middle, Hill Route Number			7.0.40
C, 180	es 1 and 2 s of Health an 1 item 27 is i ir other traus		Valerie Matthew	s siste		9 E.	Pat	apsco	7A c	7e. Ba	lto	. MD	
	permit. Pages Department of I Important: If it eny injury or o once.		1 Surial 2 Cremation 3 F 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens F.N.Walker J	88	√St. Re	st Ce	em.	11Ma		005 eral S e Balt		nover ice P MD 21	
	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or compishock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enial underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a Due to (or a) Due to	the death. Do not e	nter the mod	le of dying	, such as c	ardiac o	r respiratory ar	rest,		Approximate Interval Between Onset and Death
, vo	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d	of pregnancy 2	B⊟Ectopic pr B⊟ Other (sp	ecify)					23d. Date of d Month	Day Year
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	The ate ha	e Completed	25. Was case referred to medical					26. Place	of Death	24a. Was autop perfor 1 Yes	rmed?		
5	ing Phys	atlon; To B	examiner?  1 Yes 2 No  27. Manner of Death  Natural 5 Pending 2 Accident investigation	lospital: 1  Inpatier 28a. Date of Injun (Month, Day	y 28b. Time		8c. Injury Work	r: 4 🗆 Nurs	sing Hom	200	lence 6	Other (Sp	pecify)
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	To the Hospital or within 24 hours after To the Funeral Director completely filled in b	Medical	29a. Certifier (Check only one)  Control one)  Control one on title of certifier	sician: To the best oner: On the basis of and manner state	examination and/or	investigation,	in my opi	inion, death	place, a occurre	d at the time, o	date and	place, and du	ue to the cause(s)
		~	29b. Signature and title of certifier	NEN	w		License						2005
	U		30. Name and address of person who co	BCHO,	eath (Item 23a) (Type	9. Print) 8 Sout	th GR	FERF	54.	Balt	mor	o Mg	2005
	Sta Registr		31. Date filed (Month, Day, Year)  MAY 1 2 2005	32. Registra	r's Signature	de)				,		,	,

			For State Registrar	State of Ma	aryland / I		rtment of F		Mental Hyg	- m	05	16100
			Hegistrar     Decedent's Name (First, Middle,	Last)			intoate of	Jean	2. Date of Deat			3. Time of Death
	Physici		Marni Wanio	e	McNio	cho1			Month 5	Day	2005	5:30 A M
П	/Medic Examin		4a. Facility Name (If not institution,	give street and number)			4b. City, Town, o	Location of Deat	h	4c. Cou	unty of Death	1
			115 Ferndale A				Glen B				Anne	Arundel
	Funeral			. Sex 7. Age 1  M 2  F	e (In yrs. last bii 48	rthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		Year)	9. Birthp Count PA	nlace (State or Foreign ntry)
	Director		184-48-8559 Usual Residence of Decedent	- 77		+13.			UCT. 27	,1936	PA	
	yland yland		10a. State 10b. County		10c. City, Tow	n or Lo	cation				1	0d. Inside City Limits
	Mar Milited	ctor	MD Anne	Arunde1		G1	en Burni	e				1 ☐ Yes 2 XNo
	ih the or 28	Jire	10e. Street and Number				10f. Zip Code		1	-	of What Coun	ntry?
	ath w	rai	115 Ferndale A				210				.S.A.	
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural; or Itams 23e or 28e-f show aumatic event, in e Madical Examination must be notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 → Married  3 □ Widowed 4 □ Divorced	12. Was Decedent I Armed Forces? 1 Yes 2 Yes If Yes, Give X Year or Dates:		1	Vas Decedent of H i Yes, specify Cuba Yes 2 No	ispanic Origin? (S in, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)		Race - Americ Black, White, ec <i>ify:</i>	
21215-0036	2 hou atura	ted	15. Decedent's	Education	16a	. Deced	ent's Usual Occup	ation		16b. Kind o	of Business/Inc	dustry
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<u>n</u>	be fill d oth evan	Be	17. Father's Name (First, Middle, La	_					me (First, Middle, M		/	
Maryland	should be nd Mental markad c	<sup>L</sup>	James Craig		and 10th	Moilie	a Address (Street		ry Jane I			Codol
Z	is 1 and 2 should of Health and Men item 27 Is marks other traumatic		Mr. John Patric						Glen Burr	,		,
a a	Health tem 27 othar tra		20a. Method of Disposition		20b. Place o	f Dispo	sition (Name of	T -			on - City or To	
ê E	Pages ent of nt: If i		1 Burial 2 □ Cremation 3  `4 □ Donation 5 □ Other (Spe			-	natory or other place n Mem. P		13,2005	Glen H	Burnie,	MD
Baltimore,	permit. Pages Department of H Important: If ite any injury or of once.		21. Signature of Johanal Service Lie	• •	mnizi	22	Name and Addre	ss of Facility Si	ngleton I	Tunera	al Home	P.A.
			23a. Part1. Enter the disease, or co	omplications that caused	the death. Do						ire, in	Approximate
ı	hysician		shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	a.	10.	文	Cano	25				Onset and Death
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Ö,	icate be executed physician and s the burial-transit	i Ex	resulting in death) Last	Due to (or as	a consequence	of):						
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			IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome						23d.	Date of delive	NO.
ň	law requires that the death certif as been signed by the attending 2 should be detached for use a:	Physician/M	in the past 12 nonths?  1 \( \sum \text{Yes}  2 \) \( \text{No} \)	1□Live birth 4□Pregnant at			Ectopic pregnancy Other (specify)					Day Year
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Vital	aician: Th certificate irector, pag	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 No	Hospital:		:	Oth	ar.	ath (Check only one			
ō	y Phys er this eral di	-	27. Manner of Death	1 ☐ Inpatie	y 28b.	Time of	3 DOA 28c. Injun Worl	4   Nursing F	lome 5 Reside 28d. Describe ho			/)
0	nding P ath. r: After i e funera	atio	Natural 5 Pending 2 Accident Investiga	(Month, Day	Year)	njury		k? Yes 2 □ No				
Division	r Attendi er death. ractor: A by the fu	Certification;	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		ury - At home, fa	ırm, stre	et, factory, office		28f. Location (Str City or Town	reet and Nu State)	imber or Rura	l Route Number,
ے	ital o											
	To the Hospital or Attending Physician: within 24 hours after death To the Funarel Director: After this certifica completely filled in by the funeral director,	Medical	29a. Certifier 1 Certifying (Check only one) 1 Madical Exponential Certifying 2 Madical Certifyi	Physician: To the best of aminer: On the basis of and manner sta	examination ar	e, death id/or inv	occurred at the tin estigation, in my o	ne, date and place pinion, death occu	e, and due to the ca urred at the time, da	use(s) and ite and plac	manner as sta ce, and due to	ated. the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	201	1		29c. License	number	29	d. Date sig	gned (Month, L	Day, Year)
			1/1/2	01			1.4)	515	/	/1a/	10,	200)
	12		30 Pame and address of person w	Deluenn	031	(Type,	HOSA	Hd av	2 6/ev	Dur	n M.	2/06/
	Sta <del>R</del> egistr		31. Date filed (Month, Day, Year)	32. Begistra	ar's Signature	Lo	ests)					,

			1 - State		artment of He			affin affin and	Company of the Compan
			Registrar  1. Decedent's Name (First, Middle, Last)		lilicate of D	Calli	2. Date of Death	g. No.	3. Time of Death
	Physicia		Velma Virginia Martin				Month		7:49P M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or L	ocation of Death	May 5,	4c. County of	
	Examili	ei	3102 Birch Brook Lane		Abinadon			Harf	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. la	st birthday)	If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	q	Birthplace (State or Foreign Country)
	Director		218-18-5615 1 M 2 MF 88	3 Yrs.	Moritis Days	Hours Will.	Nov. 30	, 1916 M	Maryland
	p z		Usual Residence of Decedent  10a. State 10b. County 10c. City,	Town or Lo	cation				10d. Inside City Limits
	sho	ŏ			oution.				1 ☐ Yes 2 🛣 No
	28a-f	Director	Maryland Harford Abir	ngdon	10f. Zip Code		10	g. Citizen of Wha	at Country?
	with Sa or		3102 Birch Brook Lane		21009	)		USA	
	J within 72 hours atter death with the Maryland jiene. Than "natural; or items 23a or 28a-f show Itte Macilcal Examitrer must be notified at	Funeral	11. Marital Status 12. Was Decedent Ever in U.S	i. 13. y	Was Decedent of Hisp f Yes, specify Cuban,		cify Yes or No-	14. Race -	American Indian,
٥	atter or ite		Armed Forces?  1 ☐ Never Married 2 ☐ Married 1 ☐ Yes, Give			Specify:	Hican, etc.)		White, etc.
215-0036	ours iral',	d by	3X Widowed 4 □ Divorced Year or Dates:		22110	эрөспу.		Specify:	White
ភ	72 h "natu	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupation  kind of work done dui  DO NOT use retired)		ng 1	6b. Kind of Busin	ness/Industry
7	within 72 ene. than "nat	du	Elementary/Secondary (0-12) College (1-4or 5+)		emaker			Own Hom	<b>1</b> 0
N	be filed ital Hygie d other evant, II		17. Father's Name (First, Middle, Last)	11011		8. Mother's Name	(First, Middle, M		
Maryland	m - 0 5	To Be	Frank Joseph Peters		F	florence	May	Bolst	ridge
<u> </u>	shoul nd Mo mark	Ĕ	19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street and				
	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Itam 27 Is marked any Injury or other traumatic evonce.		Patricia L. Warren - Daughter	3102	Birch Broo	ok Lane,	Abingdo	n, Maryl	and 21009
Baltimore,	s 1 a f Hez itam othe		Ca	ace of Dispo	sition (Name of natory or other place)		ate 2	Oc. Location - Cit	ty or Town, State
Ë	Page nent c int: If iry or		1 EdBurial 2 Cremation 3 Hemoval from State	•	Cemetery	5/11/	/05 B	altimore	, Maryland
<u>a</u>	permit. Departminimporta		21. Signature of Funeral Service Licensee		. Name and Address				Iome, P.A.
מ	89 = 8		Stepley a light	1	317 Cokest	oury Road	d, Abing	don, Mar	yland 21009
			23a. Parti. Enter the disease, or complication that caused the death. shock, or heart failure. List only one cause on each line.	Do not ente	er the mode of dying,	such as cardiac o	r respiratory arre	st,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	(69)	Coxcass	J-			Onset and Death  S GCUL
	/Medical Examiner		resulting in death)  Due to (or as a consequence)	ance of):		<del></del>			
	LAdiffille	L	Sequentially list conditions, if any, leading to immediate Due to (or as a consequi						
1	ed isit	Examiner	if any, leading to immediate cause. Enter Under, in Cause (Disease or injury	anca or):					
_	be executed ician and burial-transit	xan	that initiated events c.  resulting in death) Last  Due to (or as a consequence)	ence of):					=
/60,	ate be executed hysician and the burial-transit	caiE	d						
89	death certificate e attending physiol tor use as the		U.						
ŏ	leath certifical attending phy I tor use as th	D/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnant		Tratagia agamanay			23d. Date of	of delivery
n		icla	in the past 12 months?  1  Yes 2 No  1 Yes 2 No  1 Yes 2 No		Ectopic pregnancy Other (specify)			Month	Day Year
J Ö	at the de by the a tached t	Physician/Med	9 ☐ Unknown						
Ś	The law requires that the tee has been signed by the bage 2 should be detached.	by F	Part II. Other significant conditions contributing to death but not result	ting in the ur	nderlying cause given	in Part I.		6.3	ute to the cause of death?
ecord	w requir been si should I						1 Tes	s 200 31	☐ Probably 4 ☐Unknown
ပ္	law ras be	ple					24a. Was an autopsy	prio	re autopsy findings available ir to completion of cause of
r =		Completed					perform 1 ☐ Yes 2		ith?  Yes 2□ No
Vita	Physician: The law rthis certificate has l ral director, page 2 s	Be	25. Was case referred to medical examiner?			6. Place of Death	(Check only one	)	
0	his his	- To	1 192 5 100 1 1 Inbatient 5 1	R/Outpatien 28b. Time of		4   Nursing Hor	ne 5 Resider 28d. Describe hov		(Specify)
	Jing Attel	tion	1 Statural 5 ☐ Pending (Month, Day Year)	Injury	Work?	s 2 □ No	280. Describe not	w injury occurred	
Division	or Attending atter death. Diractor: Attel in by the tune	fica	3 Suicide 6 Could not be 28e. Place of Injury - At hor	ne, farm, str			28f. Location (Str	eet and Number	or Rural Route Number,
2	atter Dira Dira	Certification:	4 Homicide determined building, etc. (Specify)		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Town,	State)	
	To the Hospital or Attend within 24 hours atter death To the Funaral Director: completely filled in by the		29a. Certifier 12 Certifying Physician: To the best of my know	rledge, death	n occurred at the time,	date and place, a	and due to the car	use(s) and mann	er as stated.
	ns Ho	edicai	(Check only one) 2 Medical Exeminer: On the basis of examinations and manner stated.	on and/or inv	vestigation, in my opin	nion, death occurre	ed at the time, da	te and place, and	due to the cause(s)
	To the within To the comp	×	29b. Signature and title of certifier		29c. License r	number	7	d. Date signed (	yonth, Day, Year)
					1)	840	1	1/6/0	2)
	, 6		30. Name and address of person who completed cause of death (Item	23а) (Туре,	Print)	n AF	ZAIR	MT	21014
	/0		170 1HANT 602 S.	HIWI	ע עני	) 000	UMIR	11/1/	7
	Sta Registr		31. Date filed (Month, Day, Year)  MAY 1 2 2005	K A	books				/

			For Stete Registrar	State of Ma	ryland / De	epartment Dertificate	t of H	ealth a		lental Hy	giene	4000	16102	)
			Decedent's Name (First, Middle, Last)		· · · · · · · · · · · · · · · · · · ·			- Calir		2. Date of Dea	ath		3. Time of Death	_
н	Physici		Virginia Mild:	red Mille	r					Month	9Day	2005	5.00A M	i
	/Medio Examin		4a. Fecility Name (If not institution, give s			4b. City,	Town, or	Location o	of Death	0	4c.	County of Dea	ath	
			Keswick Multi-(	Care			ltim							
	Funeral		5. Social Security Number 6. Sex	7. Age	(In yrs. last birth	Months	1 Year Days	If Under : Hours	24 Hrs. Min.	8. Date of Birt (Month, Da May 3,	th y, Year)	9. Bi	irthplace (State or Foreigr Country)	7
	Director		218-14-7001 Usual Residence of Decedent	7.11. 20.	86 Y	S.				May 3,	1919	Ma:	ryland	
	land		10a. State 10b. County		10c. City, Town	or Location							10d. Inside City Limits	_
	Hary	ţo	Maryland			Baltimo:	re						1X Yes 2 ☐ No	,
	r 28e	lrec	10e. Street and Number			10f. Zip					10g. Cit	izen of What C	Country?	_
	th wit	aiD	631 East 29th S	Street				21218	1.5			U.S.A.		
	ems rdea	Iner	11. Marital Status	12. Was Decedent E Armed Forces?		13. Was Deced If Yes, spec	ent of Hi	spanic Orig	gin? (Spe	cify Yes or No- Rican, etc.)	-	14. Race - Am Black, Wh		
36	or It	Y.	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ N If Yes, Give	0	1 ☐ Yes 2		Specify:				Specify:		
Ö	filed within 72 hours after death with the Maryland Hygiene. uther then "naturel", or Items 23a or 28e-f show ant, the Medical Examiner must be neiffied at	Completed by Funeral Director	15. Decedent's Educ	Year or Dates:	16a F	ecedent's Usua	I Occupa	ation			16b K	W. ind of Busines	hite s/hdustry	
5	in 72 n "na	plet	(Specify only highest grade	e completed)		Give kind of wor life. DO NOT us	k done d	luring most )	t of workii	ng	100.10	and or business	a made on y	
212	1 with jiene. r the	mo	Elementary/Secondary (0-12)	College (1-4or 5-		ales Cle	erk				W	oolwort	h's	
פ	othe vent,	BeC	17. Father's Name (First, Middle, Last)					18. Mothe	r's Name	(First, Middle,	Maiden	Surname)		
<u>la</u>	Menta	70	Thomas Miller					Ne1	lie	O'Brier	1			
Maryland 21215-0036	2 sho		19a. Informant's Name/Relationship (Type	pe, Print)	19b. N	Mailing Address	(Street a	and Numbe						
2	l and lealth im 27 her ti			Niece)		241 Day				lenelg,		ryland ocation - City o		4
Baltimore,	iges 1 nt of the if ite or of		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	-	Disposition (Nam crematory or of								
Ħ	t. Pa ntmer rtent: njury		' 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of nerghService License		New Ca	thedral							Maryland	_
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or Items 23s or 28e-1 show emportent: other treumatic event, the Modical Examiner must be notified at once.		21. Signature of inerging rice License	//	101290	Witzke 1630 Ed	Fun Imon	eral dson	Home Aven	of Cat ue Cat	ons	ville, ville,	Inc. MD 21228	
			23a. Part 1. Enter the disease, or complications, or heart failure. List only on Immediate Cause (Final	ne cause on each lin	е.						rrest,		Approximate Interval Between Onset and Death	
	Physician /Medical		disease or condition resulting in death)	Vletaste	consequence of	cfal	الملك الملك	un	ma	>			Imonths'	_
Н	Examiner			·	consequence of	,.								
L,		Jer	Sequentially list conditions, 1 and 15 immediate cause. Enter Underlying Cause (Disease or injury		consequence of	):								
$\bigvee$	outed ad ransit	Examiner	that initiated events											
,092	be executed ician and burial-transit	EX	resulting in death) Last	Due to (or as a	consequence of	):								
876	e y e	licai	d											
89 x	that the death certifica ed by the attending ph detached for use as th	by Physician/Med	IF FEMALE:	20 If you guitagen	of programmy									-
Вох	attenc for us	ian	in the past 12 months?	3c. If yes, outcome of 1 ☐ Live birth 3 4 ☐ Pregnant at	2 Fetel death	3 ☐Ectopic pre						23d. Date of de Month	elivery Day Year	
o.	he de	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□ Unknown	ume or death	5 □ Other (spe	9¢11 <b>y</b> )							
<u>α</u>	The law requires that the ate has been signed by the page 2 should be detache	Y Ph	Part II. Other significant conditions con	tributing to death bu	it not resulting in t	he underlying ca	ause give	n in Part I.		23e. Did to	obacco u	use contribute	to the cause of death?	
rds,	w requires that been signed to should be deta									101	res 2	BNo 3□P	robably 4 Unknown	
Ö	w rec	lete								24a. Was		24b. Were a	utopsy findings available	,
Re	The lav te has age 2 :	Completed									osy rmed? 2 ₩√o	death?		
Vital Record		BeC	25. Was case referred to medical					26. Place	of Death	(Chack only o		10.0	3 2 140	_
<b>&gt;</b>	Physicien: this certific ral director,	ToE	examiner? 1 ☐ Yes 2 ☑ No H	lospital: 1 🗆 Inpatier	nt 2 EP/Outp	atient 3 DO	A Othe	er: 4 4 4	rsing Hor	me 5 🗆 Resid	dence	6 □Other (Sp	ecify)	
n of	ng fter	:uo	27. Mann f Death 1 Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	y 28b. Tir Year) Inj	me of 28 ury	Bc. Injury Work	at	2	28d. Describe t	now injur	y occurred		
sio	Attending r death. ector: After by the fune	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be			М		/es 2□I			2			
Division	or Ati fter d Sirect in by	Certification:	4 Homicide determined	28e. Place of Inju building, etc	ry - At home, farn . (Specify)	n, street, factory	, office		1	28f. Location (5 City or Tox			Rural Route Number,	
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu		29a. Certifier 1 Certifying Phys	sician: To the best o	f my knowledge,	death occurred a	at the tim	e, date and	d place, a	and due to the	cause(s)	and manner a	s stated.	11
	the Ho in 24 I the Fu ipletely	ledical	(Check only 2 Medical Examir one)	ner: On the basis of and manner sta	examination and/ ted. 				th occurre					
	To To COL	Σ	29b. Signature and title of certifier	Λ	011 1-1			number				te signed (Mon	-	
,			TVI Dakelle V (1)	it gre	yer m			57			dely	10,2	000	
_	10		30. Name and address of person who co	SREGOR,	701) (T	ype, Print) W. 40 9	th S	T - 1	BAL	JO - 070	) 2	1211		
	Sta Registi		30. Name and address of person who com Is ABELLE Vibe 31. Date filed (Month, Day, Year)  MAY 1 2 2	32. Regista 2005	r's Signature	Spark								

			1 - For State Registrar	12-		f Maryla	nd / Depa	artment <i>rtificate</i>			nd M		giene Reg. No.	005	16	103
	Physici /Medi		1. Decedent's Name ( Stephar		<sub>Last)</sub> y Matara	zzo						2. Date of De	ath Day	2 Ďれて	3. Time o	of Death
	Examir		4a. Facility Name (If n	AGN	ES HE	ALTH	CARE	4b. City, To	BA	TIM	non	E		inty of Death		
	Funeral Director		5. Social Security Nun 214-03-354		.Sex 1 ☐ M 2 💢 F	7. Age (In yrs 90	. last birthday) Yrs.	If Under 1 Months [	Year Days	Hours	4 Hrs. Min.	8. Date of Bir (Month, Da Oct. 26	th 19, Year) 1914	9. Birth Cou Mary	olace (State ntry) Land	or Foreign
	pu *		Usual Residence of D 10a. State 1	ecedent 10b. County		100.0	ity, Town or Lo	1								
	Maryla f shor	ō		Baltimo	re		Catonsv								10d. Inside C 1 □ Yes	s 2 No
	h the l	<b>Funeral Director</b>	10e. Street and Numb	oer				10f. Zip Ci	ode				10g. Citizen	of What Cou	ntry?	
	23a c	ralD	709 Maider	n Choic	e Lane F	RGT 426		212	228				USA			
	er dez Items	nue	11. Marital Status	A OF Massics	12. Was Dece Amed Fo	dent Ever in I	J.S. 13.	Was Deceder If Yes, specify	nt of His Cuban	panic Origi , Mexican,	in? (Spec Puerto F	cify Yes or No lican, etc.)	14. [	Race - Ameri Black, White,		
920	urs aft ai', or	þ	1 ☐ Never Married 3 🌠 Widowed 4	_	d 1 □Yes If Yes, Giv Year or D	e Atlas:		1□Yes 2X	□ No	Specify:			Spe	ocify: Whi	te	
4	Virt 13-0030  within 72 hours after death with the Maryland ane.  then "natural, or items 23e or 28e-f show then "natural be invitified at the Madical Examination and the invitified at	eted		5. Decedent's only highest of	Education grade completed)		16a. Dece (Give	dent's Usual ( kind of work of DO NOT use	Occupati done du	ion iring most	of workin	g	16b. Kind a	f Business/In	dustry	
2	within ene.	mpi	Elementary/Second	lary (0-12)	College (1	-4or 5+)		<i>DO NOT use</i> memake:					orm h	2000		
Man/and 21215_0036	VICT YICH IN ZIZIN 12 should be filled within h and Mental Hygiene. 7 Is marked other then " treumatic event, the Med	Be Completed	17. Father's Name (Fi	irst, Middle, La	ist)		110	шешаке		18. Mother	's Name	(First, Middle	OWN he			
2	yidi buld be Menta Menta arked artic ev	To B	Rosario M	annone								a Sarco				
Š	VICE Show the and 7 Is m		19a. Informant's Nam Antoinette			nter						Route Number			Code)	
	Healt Healt tem 2		20a. Method of Dispos			20b.	Place of Dispo	sition (Name	of			ite		on - City or To	own, State	
Ē	Pages nent of int: If i		1 X Burial 2 □ 0 `4 □ Donation 5		☐Removal from : cify)		cemetery, crei dens o			Ma	ay 7	,2005	Raltim	ore, M	D	
1100 1000 1000 1000 1000 1000 1000 100	parmit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Deparmit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Department of Health and Mental Hygene. Importent: If them 27 Is marked other then "natural", or items 23a or 28e-1 show any injury or other treumatic event. The Madical Examination and be invilled at once.		21. Signature of Fune	eral Service Lic	anhe	1						wab Fu Baltir				
•	rnysician /Medical Examiner		23a. Part1. Enter the shock, or heart f Immediate Cause (Fir disease or condition resulting in death)	failure. List on	omplications that cally one cause on e a	ANY or as a conse	th. Do not ent	er the mode o	of dying,	such as c	ardiac or			M	Approximat Interval Bet Onset and	W/V
V		Examiner	Sequentially list condi if any, leading to imm cause. Enter Underly Cause (Diseese or in)	litions, lediate ring ury	b. 910 DIA	ONIC or as a conse	REW/ quence of): 5 M#	TLIT							IKNDI UCN DI	
8760	ate be executed shysician and the burial-transit	dicai Exa	that initiated events resulting in death) Las	st	d. Pht	or as a conse	quence of):								NICHB	
7 2	death certifi death certifi e attending I	Physician/Med	IF FEMALE: 23b. Was decedent p in the past 12 m 1  Yes 2 N 9 Unknown	onths?		inth 2 ☐ Fet ant at time of	aldeath 3□	Ectopic pregi Other (speci						Date of delive		Year
Myllit rde p			Part II. Other significa	ant conditions	ontributing to de	ath but not re	sulting in the u	nderlying caus	se given	in Part I.		23e. Did to	obacco use c res 2 No		ne cause of cably 4 🗆	
), (YEPHANIE	The law ate has b page 2 sl	Completed by	MARIT	. /	AVVEY	Y D	ISEAS	E			_	24a. Was autop perfo 1 Yes	sy	b. Were auto prior to con death? 1 \( \sum \text{Yes}	npletion of c	available cause of
, iv	Physicien: The Prysicien: The Price It is certificate har all director, page	Be	25. Was case referred examiner?	d to medical	Hospitals - /						of Death	(Check only o	ne)			
26	Phys rat dii	1: To	1 ☐ Yes 2 No.	0		npatient 2 [ of Injury h, Day Year)	ER/Outpatier		Other:	4 🗀 14013	_	e 5 Resid			/)	
AZ	Attending Ph r death.	atior	1 Alatural 2 Accident	5 Pending investigati		h, Day Year)	Injury	М	. Injury a Work? 1 □ Ye	s 2 🗆 No						
THCA2	in the	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not determine	t be ed 28e. Place buildin	of Injury - At h ng, etc. <i>(Speci</i>	nome, farm, str	eet, factory, o	office		28	3f. Location (3 City or Tox	Street and Nu vn, State)	mber or Rura	l Route Num	iber,
VA7	Hospite 4 hours Funeral ely filled	edical C	29a. Certifier 1 (Check only 2 one)	Certifying f	Physician: To the eminer: On the ba	isis of examina	owledge, death ation and/or in	n occurred at t vestigation, in	the time, my opin	, date and nion, death	place, ar	nd due to the	cause(s) and date and plac	manner as st e, and due to	ated. the cause(s	s)
	To the within 2 To the complet	Me	29b. Signature and titl	le of certifier		il			icense r	_			29d. Date sig	ned (Month,	Day, Year)	
			M	mai	MEDI	car	ESI DEM	7	1	842	0	/	MAY	05	200	5
	5		30. Name and address	HWH	Acorpleted 3	POPP NO	1/232 74	Print)	n 0-		h/ \/	14.00		,		
			24 Data Start (14-ath	Day Yearl	700 C77	aistrar's Sign	ve cr	74 /M/L	IKE	INM	KYL	410	21229	7		
	Sta	ite	31. Date filed (Month,	AY 1 2	32. 6	Silai S Sign	ature									

			1 - For State of Maryland / Department Certification	nt of Health and Men te of Death	tal Hygier	4000	16104
	Physicia	an	1. Decedent's Name (First, Middle, Last)	12.5	Date of Death	Day S Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give street and number)  4b. City	, Town, or Location of Death		4c. County of Death	,
	Funeral Director		220-36-75 12 M 2 F 63 Yrs. Months	ALTIMOR or 1 Year If Under 24 Hrs. 8. p Days Hours Min.	Date of Birth Month, Day, Ye.	9. Birthp Coun 1942 MA	A lace (State or Foreign try) - RYLAND
	nyland how		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	n	~	11	Od. Inside City Limits
	the Ma 28e-f s	Funeral Director	MARYLAND NA 9.  10e, Street and Number 10f. Zi	OALTIMORE ip Code		citizen of What Coun	1. Yes 2 □ No
	23e or	ral Di	2517 MCCULLOH STREET	21217		45.	
036	ours after dea el', or Items Exeminario	by	3 ☐ Widowed 4 ☑ Divorced Year or Dates:	edent of Hispanic Origin? (Specify ecify Cuban, Mexican, Puerto Rica 2 X No Specify:	Yes or No- n, etc.)	14. Race - Americ Black, White,	
21215-0036	within 72 hours after death with the Maryland ene. then "returel", or Items 23e or 28e-f show the Medical Excipier must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)  Bementary/Secondary (0-12)  College (1-4or 5+)  ARTIST	ual Occupation ork done during most of working use retired)	1	Kind of Business/Inc	dustry
Maryland 2	ges 1 and 2 should be filed within 72 hours after death with the Marylan It of Health and Mental Hygiene. If item 27 is marked other then "neturel; or items 23e or 28e-1 show or other traumatic event. The Medical Examinar must be notified at	To Be Co	17. Father's Name (First, Middle, Last)  ARTHUR BREWER	18. Mother's Name (Fir	rst, Middle, Maid NE	len Sumame) PALM	1ER
	1 and 2 sh Health and Iem 27 Is m		C'ATHERINE PALMER (DAUGHTER) 3 107	ss (Street and Number or Rural Ro	BAL		21244
Baltimore,	t. Pa ntmen rtant: njury		We Burial 2 □ Cremation 3 □ Removal from State  '4 □ Donation 5 □ Other (Specify)  MT. ZION	EMETERY 05-13-	-05 L	ANS DOWN	E, HA.
ä	Dermi Depar Impo eny ir		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mo	POD. FULTON	AVE.	BALTO, MI	ERAL HOME D. 21217 Approximate
Į	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):	n i ,	u(05	is	Interval Between Onset and Death
	Examiner		Sequentially list conditions b.				
8760,	death certificate be executed e attending physician and ad for use as the burial-transit	dical Examiner					
9	leath certifical attending phy I for use as th	/Medi	IF FEMALE: 23c. If yes, outcome of pregnancy				
.O. Box	che the	Physician/Me	23b. Was decedent pregnant in the past 12 months?  1 □ Ves 2 □ No  9 □ Unknown			23d. Date of delive Month	ny Day Year
ords, P	v requires that been signed by should be deta	by	Partie Street significant continuous continuous to death but not resulting in the underlying	cause given in Part I.	23e. Did tobacc	couse contribute to the	A .
Vital Records,	The law ate has t page 2 s	Completed			24a. Was an autopsy performed 1 ☐ Yes 2 ☑	?_   death?	osy findings available inpletion of cause of
f Vita	Physicien: Th this certificate ral director, pag	To Be	examiner?	26. Place of Death (Ch OA Other: 4 ☐ Nursing Home		6 ☐ Other (Specify	r)
ion of	Jing T. After fune			28c. Injury at 28d. Work? 1 ☐ Yes 2 ☐ No	Describe how in	njury occurred	
Division	i i i i	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, facto building, etc. (Specify)	ry, office 28f. I	Location (Street City or Town, St	and Number or Rura ate)	Route Number,
	To the Hospitel within 24 hours a To the Funerel completely filled	edical	29a. Certifier (Check only one)  1 12 Certifying Physician: To the best of my knowledge, death occurred to the basis of examination and/or investigation and manner stated.	d at the time, date and place, and on, in my opinion, death occurred at	due to the cause t the time, date	e(s) and manner as st and place, and due to	ated. the cause(s)
)	To the To the comp	M	29b. Signature and title of certifier  29b. Mary 100 Mary	DUTTS 22	29d.	Date signed (Month, 1	Day, Year)
	6		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  HM TEAGUE 22 5. Green	e St Bal	& M	0212	701
	Sta Registr		MAV 1 0 000F F	')			

	4	L. State	State of Maryl		artment of Hertificate of D			jiene	1/15	15105
		Registrar  1. Decedent's Name (First, Middle, Last)			timouto or E	-	2. Date of Dea	ith	** <u> </u>	3. Time of Death
Physicia							May 9,	Day 2005	Year	1:00 A M
/Medic	al -	Sam Papa  4a. Facility Name (If not institution, give str	eet and number)		4b. City, Town, or	Location of Death			nty of Death	1.00 11
Examin	er	Ellicott Health and		ntr	Ellicot	t City		Ho	ward	
		5. Social Security Number 6. Sex		yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birtl (Month, Day			place (State or Foreign ntry)
Funeral Director		J. 600 a. 600 a.	A 2□F	89 Yrs.	Months Days	Hours Min.	April 1	8,191	6 Mary	land
		Usual Residence of Decedent								404 Inside City Limite
yland 10W		10a. State 10b. County	10c	. City, Town or Lo	ocation					10d. Inside City Limits 1 ☐ Yes 2∑ No
Mar	ţ	Maryland Howard		E11i	cott City					
r 282	Director	10e. Street and Number			10f. Zip Code				of What Cou	ntry?
h wit		9206 Frederick Ro	ad		21042				.S.A.	and Indian
deat	Funeral	11. Marital Status	. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (S n, Mexican, Puert	pecify Yes or No- o Rican, etc.)	- 14.	Race - Ameri Black, White	
filed within 72 hours after death with the Maryland Hygione strier than "natural", or Items 23a or 28a-f show ent, the Modical Examiner must by notified at	F	1 Never Married 2 Married	1 X Yes 2 No ]		1 ☐ Yes 2 ☑ No	Specify:		Spi	ecity: W	hite
ours ral',	d by	3 ☐ Widowed 4 ☒ Divorced		1946	dent's Usual Occupa	ation		16b. Kind o	of Business/li	ndustry
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han ne	mp	Elementary/Secondary (0-12)	College (1-4or 5+)		arber	,		Barb	er Sho	р
lled v lygie her t		10 17. Father's Name (First, Middle, Last)			arber	18. Mother's Nar	ne (First, Middle,			
be find had be sad of	Be	Salvatore Papa				Josephi	ne Alaso	cia		
a Mer nark	၉	19a. Informant's Name/Relationship (Typ	e Print)	19b. Mail	ing Address (Street				wn, State, Z	ip Code)
12 st h and 7 is n					Frederic					land 21042
s 1 and 2 should be filed within 72 hours after death with the Marylan af Health, and Mental Hygiene. If Health, and Mental Hygiene. Other traumatic svent, the Modical Examinar must be notified at		Anne Farrell (Si	ster)	Ob. Place of Disc	osition (Name of		Date	20c. Locat	ion - City or 1	Town, State
ges # it of h		1 ⊠ Burial 2 ☐ Cremation 3 ☐ Re	moval from State	•	ematory or other place	!	2-2005	Dol+i	moro	Maryland
rmit. Pages partment of portant: If it y injury or o		* 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature ☐ Ineral Service ☐ ense			nedral Cem	ss of Facility	2			Maryrand
permit. Pages 1 and 2 should be filed within 7 beartment of Healins and Mental Hygiene Important: if item 27 is marked other than "n any injury or other traumatic svent, the Med once.		21. Signature puneral Service delise		1290	litzke Fur 630 Edmor	eral Hon	ne of Car	tonsvi	lle, J	nc. 21228
4 402 80		23a. Part1. Enter the disease, or complic	ations that caused the	death. Do not e	nter the mode of dyin	ng, such as cardia	c or respiratory a	rrest,	, FID 2	Approximate Interval Between
		shock, or heart failure. List only on	e cause on each line.							Onset and Death
Physician		Immediate Cause (Final disease or condition resulting in death)	DEMEN							
/Medical Examiner		Todating in dealing	Due to (or as a co	nsequence of):						
	ē	Sequentially list conditions, b	Due to (or as a co	onsequence of):						
be isit	ine	Sequentially list conditions, immediate cause. Enter Underlying Cause (Disease or injury								
certificate be executed rights and season the burial-transit	Examin	that initiated events cresulting in death) Last	Due to (or as a co	onsequence of):						
ate be e hysician the buria	calE									
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eath certific attending p	Physician/Me	IF FEMALE: 2 23b. Was decedent pregnant 2	3c. If yes, outcome of g	regnancy				230	d. Date of del	
ath ath for u	clar	in the past 12 months?	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim		□Ectopic pregnanc □ Other (specify) _	y 			Month	Day Year
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law requires that the de as been signed by the a		Part II. Other significant conditions cor	tributing to death but n	ot resulting in the	underlying cause gr	ven in Part I.				the cause of death?
sign sign	d by						1 🗆	Yes 2 🗀	No 3∏Pr	obably 4 Onknown
necolus, he law requires ! e has been sign age 2 should be	Completed						24a. Wa	s an	24b. Were at	stopsy findings available completion of cause of
has ge 2	E G						perf	ormed?	death?	_
		25. Was case referred to medical				26. Place of De	eath (Check only			
VISION OF VICEL IN Attending Physician: The reach. After this certificate his pertor. After this certificate his the funeral director. page	o Be	examiner?	lospital:	2 ER/Outpat	ient 3□ DOA Ot		Home 5 ☐ Res		□Other (Spe	cify)
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ding I	tol	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Y	ear) Injur		ork? ]Yes 2∐No				
JIVISIO or Attendi after death, Director: /	fica	3 Suicide 6 Could not be determined	28e. Place of Injury	- At home, farm,	street, factory, office		28f. Location	(Street and i	Number or R	ural Route Number,
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To the Hospital within 24 hours a To the Funeral Completely filled			sician: To the best of r	ny knowledge, de	ath occurred at the t	ime, date and pla	ce, and due to the	e cause(s) a	nd manner as	s stated.
24 h e Fur etely	edical	(Check only 2 Medical Exami	ner: On the basis of example and manner state	camination and/or	investigation, in my	opinion, death oc	CUITEU AL LITE LITTE	s, date and p	lace, and due	- 10 trib 62030(3)
To the within 2 To the comple	≥ a	29b. Signature and title of certifier			29c. Licer	ise number		29d. Date	signed (Mon	th, Day, Year)
F > F 0		1 millheter	Ne	- 1 ms	50	06056	0	INAY	7,2	-005
,		30. Name and address of person who c	ompleted cause of dea	th (Item 23a) (Typ	oe, Print)					11/14/00:0
l	7	PANKAT KHET	EXPAY O	201-10	1 13A CIC	RIVET	2 NECL	c P	13 B	HUINNIE
s S	tate	31. Date filed (Month Day, Year)	005 32. Registrar's	s Signature	Apark					
Donie	tro	= min 1 2 4 2	UUU JEELA	- July 1						

Baltimore, Maryland 21215-0036 tatent Known as

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For Stata Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Physician Month 1315 2005 Joseph Rinaldi /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE CITY SINAL HOSPITAL OF BALTIMORE If Under 1 Year II Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1**⊠**M 2□F 57 Yrs. July 11, Director 212-50-0380 Usual Residence of Decedent 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f ahow traumatic avent, Iris Madical Ext. sitratin ust be retified at 1. Yes 2 □ No MD Director Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 802 Mosher Street 21202 Funeral USA unk 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married unk 1 ☐ Yes 2 ☑ No þ Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry unk unk permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) unk unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sinai Hospital 2401 W. Belvedere Avenue Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State '4 □Donation 5 BOther (Specify) in state 21. Signature of Funeral Service Licensee Ronald S. Wade 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, ND 21201 7cm m, lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part. Enter the disease, or or m, lications that caused the Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Interventacular Honorrhage Intracraned honorrhage /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Intracronial Due to (or as a consequence of) Examiner physician and s the burial-transit Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Montal Retardation, Schizoaffective Disorder, Coroted Aneuryson, 1 Yes 2 No 3 Probably 4 Unknown, 24b. Were autopsy findings available prior to completion of cause of death? Chronic Renal Insufficiency, Hapatitis, Dysphasia, Venaus autopsy performe ormed? Insufficience 2 No 1 🗌 Yes 1 Yes Division of Vital 25. Was case referred and edical examiner? or Attending Physician: 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA After the 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time ol 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation death. М 1 ☐ Yes 2 ☐ No after death 2 Accident 6 Could not be determined within 24 hours after dea To the Funerel Directo completely filled in by th 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier CES-000 7,2005 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) McINDOE, MD CATHERINE SINAL HOSPITAL OF BALTIMORE 32. Registrar's Signature Goste 31. Date filed (Month, Day, Year) MAY 1 2 2005

DHMH 17 Rev 1/2001

State

Registrar

Meser

# with the Maryland death Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. nent of Health and Mental Hygiene. ant: If item 27 is marked other then "naturel", or Itel Baltimore, Maryland 21215-0036 permit. Page Department of Important: if any injury or once.

**Physician** 

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Examiner

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To

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**Funeral** 

Director

item 27 is marked other then "naturel", or items 23a or 28a-1 show other traumatic event, the Medical Examinar must be notified at

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Physician

/Medical

Examiner

Kandol ph	P.O. Box 68760, <
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ura	Vital
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7	<b>Jivision</b>

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year RANDOLPH 7 May 2005 7:25 p<sup>M</sup> LAURA В 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death ABERDEEN HARFORD CO 111C HANOVER STREET If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Hours 1 M XXF 68 Yrs. 554-50-8154 PENNSYLVANIA DEC. 12 1936 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MARYLAND HARFORD CO ABERDEEN 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 111 C HANOVER STREET 21001 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes XX No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify: BLACK 3 Widowed 4 Vivorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 8th grade HOMEMAKER DOMESTIC 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) SAMUEL WILLIS BUCHANAN ESTER C BUCHANAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) VAlena Barksdale/Daughter 111 C. Hanover St., Aberdeen, Maryland 21001 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, State 1 X urial 2 ☐ Cremation 3 ☐ Removal from State <sup>¹</sup> 4 □ Donation 5 □ Other (Specify) FAWN GROVE AME ZION 05-14-05 FAWN GROVE, PA. 21. Signatur of Funeral Service Lices WM C BROWN COMMUNITY FUNERAL HOME-HARFORD, P.A. 321 S PHILADELPHIA BLVD, ABERDEEN, MD 21001 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Non Small Cell hung cances retastatic Omonths disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 XYes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2**V** No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examine Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛣 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manger of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

burial-transit and physician the esn ò the signed by t certificate has page 2 funeral

To the Hospitel or Attending Physician: within 24 hours after death. To the Funerel Director: After this

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State Registrar S. SIUASAIUAM

29b. Signature and title of certifier

sailan M.D 29c. License number D45530

29d. Date signed (Month, Dav. Year) 05-10-200

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

602 S ATWOOD ROAD,

SUITE 200, BELAIR 21014

. Registrar's Signature

			For State Registrar	State of Mar		artment of H rtificate of			iene 005	16108
6-	Physici	an	Decedent's Name (First, Middle, Last)	\.	1200			2. Date of Deat Month	th Day Year	3. Time of Death
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	Director		361 <b>-</b> 05-1970 <sup>1□</sup>	M ZEF	38' Yrs.	Months Days	Hours Mir	March 2	2,1917 II.	untry) Linois
	pu s		Usual Residence of Decedent  10a. State 10b. County		IOc. City, Town or Lo	cation				10d. Inside City Limits
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	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "naturel", or items 23a or 28a-f show or other treumatic event, it is Madical Examinational by mailian at	rect	Maryland Howard  10e. Street and Number		Columb	10f. Zip Code		1	0g. Citizen of What Co	untry?
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		ner	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S. 13.	Was Decedent of H	lispanic Origin? (	Specify Yes or No- into Rican, etc.)	14. Race - Ame Black, White	
36	or It		1 Never Married 2 Married	1 ☐ Yes 2 X No If Yes, Give		1 ☐ Yes 2 🕱 No	Specify:	,	Specify:	
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Maryland	should ind Men ind marke umatic	은	Arthur Beyers  19a. Informant's Name/Relationship (Ty,		106 14-16	Add (C44		ude Kaste	City or Town, State, 2	"- O 1-)
Ma	id 2 s Ith an 17 Is r		Arthur Rehkemper	(Son)						,
ē,	f Healitem		20a. Method of Disposition		20b. Place of Dispo	Angelina position (Name of			Maryland 20c. Location - City or	
E	Page nent o int: If		1   Burial 2 □ Cremation 3 □ R  4 □ Donation 5 □ Other (Specify)	emoval from State	Camp But Cemetery	natory or other place ler Natio	ña1   5−1	3-2005	Springfield	l, Illinois
Baltimore,	permit. Pages 1 and 2 shou Department of Health and M Important: If item 27 Is mar eny injury or other treumat ance.		21. Signature of Funeral Service License	900		Name and Addre		mes, Inc.	5,1101	, IIIIII
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			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	e cause on each line.	•	ter the mode of dyir	ig, such as cardia	ac or respiratory arre	est,	Approximate Interval Between Onset and Death
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Sio	Attending or death. ector: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □ No			_
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	To the Hospitel within 24 hours a To the Funerel I completely filled	Medicai	(Check only 2 Medical Examir one)	ner: On the basis of ex and manner state	xamination and/or in	vestigation, in my o	pinion, death occ	curred at the time, da	ate and place, and due	to the cause(s)
	To t with To t	Σ	29b. Signature and title of certifier	M	λ	29c. Licens	e number	29	9d. Date signed (Month	, Day, Year)
•			William Ru	MIX III		TEO	101.	M	My 7, 20	05
	24		30. Name and address of perso who co	mpleted cause of dea	th (Item 23a) (Type,	Print) / Ha	PATTIN	ENT C	the Con	MI)
	Sta	te	31. Date filed (Month, Day, Year)	32. Regitrari	s Signature	> h1//C	11/07	CIFI (1)	10m216	
6.	Registr	93.00	MAY 1 2 2	005	. k	had .				

			1 - For State Registrar	State of Ma	-	epartm <i>Certific</i>			Mental Hy	/giene)	05   610	9
	Physici		Decedent's Name (First, Middle, Las	υ		1	Rohi	10000	2. Date of Do Month		Year Year A	
	/Medic Examin Funeral Director		4a. Facility Name (If not institution, give	dical Co	(In yrs. last birti		Sc. H	If Under 24 Hir Hours Min	s. 8. Date of Bi	4c. County rth av. Year) 1926	9. Birthplace (State or Fore) Country) Maryland	ign
S	ō		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location					10d. Inside City Limi	_
	a-f sh	ctor	MD N/A		Balti	more					1 ☑ Yes 2 ☐ N	ło
	death with the Maryland ms 23a or 28a-f show Inwal be notified at	Director	10e. Street and Number			10f.	Zip Code			10g. Citizen of	What Country?	
	eath v	Funerai	318 S. Lehigh Str	eet  12. Was Decedent Ev	ver in I.I.S	13 Was De	212		Specify Ves or N	U.S.	A .	_
030	in 72 hours after death with the Manylan 1 "natural", or Items 23s or 28s-f show Isolical Examinat must be recitied at	by	1 ☐ Never Married 2 ☐ Married 3 ☑ Wildowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates:			specify Cuba	n, Mexican, Pue Specify:	Specify Yes or No erto Rican, etc.)		ck, White, etc.  y: White,	
215-0036	within 72 hours after ene. than "natural", or Ite	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+	)		work done of Tuse retired,	etion furing most of w )	orking		dusiness/Industry	
N	Hygier ther ti	CO	12 17. Father's Name (First, Middle, Last)			Secret	ary	18. Mother's Na	ame (First, Middle		Office	_
land	ic ave	To Be	Unknown					Unkno		, wator camar	no,	
Mary	should and Men s marka umatic	-	19a. Informant's Name/Relationship (T	ype, Print)	19b.	Mailing Addr	ess (Street a			er, City or Town,	, State, Zip Code)	_
≥,	of Health Item 27 I		Evelyn Koger/God	Daughter	2	120 Ea	gle St	treet Ba			nd 21223	
20	96 → = P		20a. Method of Disposition 1 △ Burial 2 ☐ Cremation 3 ☐		20b. Place of cemeters				Date		- City or Town, State	
Saltimor	permit. Pa Departmen Important: any injury		'4 □Donation 5 □ Other (Specify, 21. Signature   FunGral Service Licens		Sacred	22. Name	and Addres	esus 5/.	Miller-D	ippel Fu	ore, Maryland neral Home Ind	c.
u	405 # a	1 (1)	28a, Part 1. Enter the disease, or comp	ligations that assessed the	ho doeth. Do e						land 21206	
	Physician		Immediate Cause (Final disease or condition	ne cause on each line	Cition	To	node or dying	, such as cardi	ac or respiratory a	irrest,	Approximate Interval Between Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or as a	consequence o	of):	7				0	_
ù		er	Sequentially list conditions, if any, leading to immediate	b. Que to (or as a	consequence of	SOOK OF	ide	Poiso	ning	- 00m	& 5HOLIS	
	cuted nd ransit	Examiner	Cause, Enter Underlying Cause (Disease or injury that initiated events	Right	Pro	wyy	tho	rox.	- (	CELLINE	3 Hours	
09/00	ificate be executed g physicien and as the burial-transit	sai Ex	resulting in death) Last	Due to lor as a	consequence o	of):			Or Menuro K	MEDICAL		
00		Aedicai	I F F F M F	<b>.</b>				0/	A RONEL			_
.C. BOX	w requires that the death certif been signed by the attending should be detached for use a:	hysician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 Mono 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at tii 9 □ Unknown	Fetal death	3 □Ectopii 5 □ Other	c pregnancy (specify)	DEATH	TATION NEED	23d. Da	te of delivery onth Day Year	
cords, P	requires that the neen signed by th hould be detache	by P	Part II. Other significant conditions co	ntributing to death but	not resulting in	the underlyin	ig cause give	n in Part I.			tribute to the cause of death?	ฑ
neco	The law re ite has bee bage 2 sho	ompleted			-				24a. Was auto perfo	psy prmed?	Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 ﷺ	е
113	cian: ertifica ector,	Be C	25. Was case referred to medical examiner?				- 1		eath (Check only			
5	Physic this crat din	: To	1 X Yes 2 No 27. Manner of Death	Hospital: 1 🔀 Inpatient 28a. Date of Injury	2 ER/Out		DOA Othe	4   Nursing	Home 5 Resi	dence 6 Oth		_
DIVISION	ending eath. or: After the fune	cation	1 □ Natural 5 □ Pending 2 ☑ Accident investigation	Month, Day		39 4	Work	res 2 KNo			iousefire	
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc.	(Specify)	hon	12		3 S	misty Le	per or Rural Route Number,	
	Hosp 24 hot Fune stely fil	edical	29a, Certifier 1 Certifying Phy (Check only one)	rsician: To the best of iner: On the basis of e and manner state	xamination and	, death occurr Vor investigat	red at the tim tion, in my op	e, date and place sinion, death occ	e, and due to the curred at the time,	cause(s) and ma date and place,	anner as stated. and due to the cause(s)	
	To the within To the comple	Me	29b. Signature and title of certifier	/			29c. License	number		29d. Date signed	d (Month, Day, Year)	
	/		30. Name and address of person who c	ompleted cause of dea	MD	Type Print	RES	000		May 1	0,2005 10 21224	
	3	ļ <sup>6</sup>	Brenda Shoo	4940	East	650	Alle	Ba	Himo	re W	PEEIE OI	_
	Sta Registr		31. Date filed (Month, Day, Year)	32. Regisfrar	s Signature	1	9	)			•	

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For Registrar	State of		d / Depa		of H	ealth a		lental Hyg	giene	005		611	0
8			Decedent's Name (First, Middle	a, Last)							2. Date of Dea	ath			3. Time of Dea	ath
	Physici		Arthur W. S	awver Jr							Month April	12.	2005 <sup>Ye</sup>	er	2:50 Pi	M
	/Medic Examir		4a. Facility Name (If not institution		per)		4b. City, T	own, or	Location of	of Death		-	County of D	Death		
			2261 Mistha	ven Lane			Gam	bri]	lls				Anne .	Arur	ndel	
	Funeral Director		5. Social Security Number 214-36-2916	6. Sex 7 1 M 2 □ F	. Age (In yrs. Ia	st birthday) Yrs.	If Under 1 Months	Year Days	If Under : Hours	24 Hrs. Min.	8. Date of Birth (Month Day Aug 16	Year)	9. 39 Ma	Birthpla Countr ary I	ce (State or Fo. 2) and	reign
	pur *		Usual Residence of Decedent  10a. State 10b. County		10c City	Town or Lo	eation							100	d. Inside City Li	mits
	Aaryli eho	ក		Arunde1	,,,,		mbril1	1 c							1 ☐ Yes 2X	
	the h	Director	10e. Street and Number				10f. Zip (				1.	10a Citiz	en of What	t Countr	2/2	
	with with	D	2261 Misthave	n Lane					2105	4			US		,.	
	TIS 2%	era	11. Marital Status	12. Was Deced	ent Ever in U.S	3. 13.	Was Decede	ent of His			ecify Yes or No-	1	4. Race - A		n Indian,	
Maryland 21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiens. and Mental Hygiens, is marked other than "natural," or items 23a or 28a-f show sumatic event, if a Medical Examinar mist be notified at	by Funeral	1 Never Married 2 Marr	Armed Force	es? A No		if Yes, specif 1 ☐ Yes 2		Specify:	, Puerto	ecify Yes or No- Rican, etc.)	1	Black, W Specify: N			
ŏ	2 hor	ted	15. Deceden	t's Education		16a. Dece	dent's Usual	Occupa	tion			16b. Kin	d of Busine	ess/Indu	istry	
2	hin 7	Completed by	(Specify only highes Elementary/Secondary (0-12)	College (1-4	lor 5+)	life.	kind of work DO NOT use	aone di retired)	uring most	of work	ng					
2	or that	Con	12	2		rea	ltor						prope	erty		
פ	al Hygie d other went, I	Be (	17. Father's Name (First, Middle,						18. Mothe	r's Name	(First, Middle,	Maiden S	Sumame)	•		
<u>a</u>	should be and Mental I	70	Arthur W. Sa	wyer Sr					Tl	nelma	a Irene	Plat	eau			
an.	2 sho and is mu		19a. Informant's Name/Relations	· · · ·		19b. Mailir	ng Address (	Street a	n <i>d Numb</i> e	r or Rura	I Route Number	r, City or	Town, Stat	te, Zip C	Code)	
	and salth n 27		Jeanette Sawye	r/spouse					n Lar	ne Ga	ambrills	, MI	210	)54		
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marke any injury or other traumatic anges.		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation  4 ☑ Donation 5 ☐ Other (S	3 □Removal from St	1 00	ace of Dispo metery, crer	sition (Name natory or oth	e of ner place	9)		Date	20c. Loc	ation - City	or Tow	n, State	
Balt	permit. Pag Department Important: any injury c once.		1. Signaturi of Ethini Savica Ronald	Licensee Di	rector	St Ba	Name and ate A	Address nato re,	s of Facility My Bo MD 2	y oard 2120	655 W.	Ba1	timor	e St	reet	
		.50	23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cau	ised the death.	Do not ent	er the mode	ot dying	, such as	cardiac o	or respiratory arr	est,		4	Approximate nterval Between	
ı	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. My	cavel	(d)	Into	ive	rion					(	Dinset and Death	R
	Examiner				as a conseque	erice or,										
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or	as a conseque	ence ot):										
	ate be executed hysician and he burial-transit	Examin	that initiated events	с												
760,	e exe ian a irial-1		resulting in death) Last	Due to (or	as a conseque	ence ot):										
	ate br	icai		d												
<b>89</b>	ing ph	Med	IF FEMALE:													
Box	it the death certifica by the attending ph tached for use as th	Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outco	me of pregnand h 2 Fetal o		Ectopic pre	gnancy				23	3d. Date of Month		y Yay Year	
0	the a	sic	1 Yes 2 No	4☐Pregnar 9☐Unknow	nt at time of dea m	ath 5□	Other (spec	cify)					WORTH	Ü	ay roar	
<u>.</u>	d by detacl		Part II. Other significant condition	In contributing to day	th but not requir	tina in the			a in Dard I		22a Did tal	bassa us	o contribut	a ta tha	cause of death	2
Hecords,	The law requires that the death certifica tte has been signed by the attending ph page 2 should be detached for use as the	ted by	Diabete		1.105		idenying cat					es 2			oly 4 Dunkn	_
ပ္တ	law r as be	Completed	thy perl	ension							24a. Was a autops		24b. Were	autops	y findings availabletion of cause	able
		Com	/ 4								perfori	med? 2 □ No	death	1?	□ No	
Vital	ysician: Th iis certificate director, pag	Bec	25. Was case referred to medical examiner?						26. Place	of Death	(Check only on					
	80 U T	10	1 Yes 2 No	Hospital: 1 🗌 Inp	atient 2 E	R/Outpatien	t 3 DOA	Other	r: 4 Nu	rsing Ho	ne 5 Reside	ence 6	Other (S	Specity)		
0 0	ding Phy h. After thi funeral (		27. Manner of Death 1 ☐Natural 5 ☐ Pendin	28a. Date of (Month,	Injury 2 Day Year) 2	28b. Time of Injury	286	c. Injury Work	at ?		28d. Describe ho	ow injury	occurred			
<u> </u>	Attendir death. ctor: Al y the fu	atic	2 Accident investig	ation	, , , ,	,,	М		es 2 🗆 N	ov						
Division	e Hospital or Atten 24 hours after deatl e Funeral Director: etely filled in by the	Certification:	3 ☐ Suicide 6 ☐ Could I 4 ☐ Homicide determ	ined 286. Place of	Injury - At hom , etc. <i>(Specily)</i>	ne, tarm, str	eet, factory,	office			28f. Location (Si City or Town		Number or	r Rural F	Route Number,	
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Medical (	29a. Certifier 1 Certifyin (Check only one)	g Physician: To the b Examiner: On the bas and manne	is of examinatio	ledge, death on and/or inv	occurred at restigation, in	the time	e, date and inion, deat	d place, a	and due to the cand at the time, d	ause(s) a late and p	ind manner place, and c	r as stated	ed. he cause(s)	
	To the To the Complete	Σ	29b. Signature and title of certifie		1		29c.	License		_	2	9d. Date	signed (Mo	onth, De	y, Year)	
			I forel	Frend			$-\mathcal{D}$	119	165			5/	110	5		
			30. Name and address of person	who completed cause		v/ //		17		и		1		/		
			Josep /	new	1/6	Vetei	rse	the	7	M	napol	11	MA	12	1401	
	Sta Registr		31. Date filed (Month, Day, Year)  MAY 1 2. 2	Ed	gistrar's Signatu	Losse	Les .				٧	,				

.s L	SWEETMA	AN	State of Maryland / De State of Maryland / De Registrar			2°005   6
			Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year
	Physicia /Medic		Samuel Sweetman		APRIL 2	3. 2005 11·34 A M
	Examin		4a. Facility Name (If not institution, give street and number) 7100 PULASKI HIGHWAY	4b. City, Town, or Location of Death BALTIMORE CITY		4c. County of Death
	Funeral Director		5. Social Security Number un k6. Sex 1 M 2 □ F 7. Age (In yrs. last birtha	Months Davs Hours Min.	8. Date of Birth (Month, Day, Ye July 1,	9. Birthplace (State of Foreign Country)
	and		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town of	r Location		10d. Inside City Limits
	Aanyi I sho	ō	MD	Baltimore		1X Yes 2 □ No
	the t	Director	10e. Street and Number	10f. Zip Code	10a.	. Citizen of What Country?
	with a or	5	7100 Pulaski Hgwy	21237		and the second second
	eath	era			pecify Yes or No-	USA 14. Race - American Indian,
39	be filed within 72 hours after death with the Maryland ital Hygiene. The man "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, the Medical Examinat must be multiped at event, the Medical Examinat must be multiped at	by Funeral	Armed Forces?  1 Never Married 2 Married  1 Yes 2 No unk  If Yes, Give  Year or Dates:	<ol> <li>Was Decedent of Hispanic Origin? (Siff Yes, specify Cuban, Mexican, Puerton 1 ☐ Yes 2 ☑ No Specify:</li> </ol>	Rican, etc.)	Black, White, etc.  Specify: white
ŏ	2 hou	ted	15. Decedent's Education 16a. De	ecedent's Usual Occupation	unk 161	b. Kind of Business/Industry unk
72	n n	ple	(Specify only highest grade completed) (G	Rive kind of work done during most of wor e. DO NOT use retired)	king	
2	d with	Completed	unk unk			
Baltimore, Maryland 21215-0036	should be filed ind Mental Hygid s marked other umatic event, I	To Be C	17. Father's Name (First, Middle, Last)	unk 18. Mother's Nam	ne (First, Middle, Mai	iden Sumame) unk
ar	s 1 and 2 should f Health and Men item 27 is marke other traumatic			ailing Address (Street and Number or Ru		
Σ	os 1 and 2 of Health a item 27 is other trace		O.C.M.E.	ll Penn Street Balt		21201
more	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other once.			isposition (Name of crematory or other place)	Date 200	c. Location - City or Town, State
Balti	permit. Departn importa any inju		21. Signafure of Euneral Service Licensee Ronard S. Wade. Director	22. Name and Address of Facility State Anatomy Board Baltimore, MD 2120		altimore Street
			23a. Part A Enter the disease, or complications that caused the death. Do not shock or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition Alcohol Intoxical	tion		Onset and Death
	/Medical		resulting in death)  Due to (or as a consequence of):			
	Examiner		Sequentially list conditions, b.			
	D #	ner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury			
	ecute ind trans	Examiner	that initiated events c.			
760,	le be executed ysician and e burial-transit		resulting in death) Last Due to (or as a consequence of):			
376	eath certificate be executed attending physician and for use as the burial-transit	Ical	d			
68	ing p	Physician/Med	IF FEMALE:			
Вох	ath ce	an/	23b. Was decedent pregnant  1 Live birth 2 Fetal death	3 ☐ Ectopic pregnancy		23d. Date of delivery  Month Day Year
	that the death hed by the atter detached for	sici	1  Yes 2 No 9 Unknown 4 Pregnant at time of death	5 Other (specify)		J2,
0.0	d by	Ph.	Part II. Other significant conditions contributing to death but not resulting in the	a undarbing saves given in Day I	23e Did tobac	co use contribute to the cause of death?
Vital Records,	Do o	i by	Faith, Other significant conditions contributing to death out for resulting in the	o underlying cause given in Part I.		2 No 3 Probably 4 □Unknown
Ö	w requir been si should	Completed			24a. Was an	24b. Were autopsy findings available
ž	has has	ш			autopsy	prior to completion of cause of
a					V2Yes 2□	No 1 Yes 2 No
<u> </u>	Attending Physician: r death. ector: After this certifica by the funeral director, g	Be	25. Was case referred to medical examiner?  Hospital:	Other	th (Check only one)	NATE OF THE COUNTY
	Phys this al di	2	1 X Yes 2 No	atient 3 DOA 4 Nursing H	ome 5 Residence 28d. Describe how	TEX TO WAIT DODGETED
L C	tending Ph leath. Ior: After th the funeral	lo	1 □Natural 5 □ Pending Found Found Found	Work?		injury occurred unk
S	ttendeath death ttor: the	cal	2 Accident investigation 3 Suicide Could not be 28e Place of Injury - At home farm		28f Location (Stree	at and Number of Bural Boute Number
Division of	or A after Direction by	Certification:	4 Homicide determined building, etc. (Specify)		City or Town, S	at and Number or Rural Route Number, State <b>7100 Pulaski Highwa</b> j
_	Hospital or Attenc 14 hours after death Funeral Director: tely filled in by the		Found on sidewall  29a. Certifier 1 Certifying Physicien: To the best of my knowledge, d		Baltimore, and due to the caus	
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical	(Check only one)  25 Medicel Examiner: On the basis of examination and/one)			
	To the I	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)
			Mounte me Thele un	OCME	. E	APRIL 24, 2005
			30. Name and address of person who completed cause of death (Item 23a) (Ty	pe, Print)		
			HARYDOWN A KORECL.	111 Penn Stree	t Baltimo	ore, Maryland 21201
	< Sta		31. Date filed MAN Day, Year 2005	de		
	Registr	ar				

			For State	State of Maryland /		nent of Hea			4000	16112
	Physici		Registrar  1. Decedent's Name (First, Middle, Last,		SOBO		2	Reg. N  Date of Death  Month  D	ay Year 1 200	
	/Medic Examir Funeral		4a. Facility Name (If not institution, give  THE SCHWS HOPKI  5. Social Security Number  6. Security Number	street and number) WS HOSFITAL	birthday) If	City, Town, or Loc. BALTIN Under 1 Year   If U	ation of Death	Date of Birth (Month, Day, Year	c. County of Dea	
	Director		Usual Residence of Decedent  10a. State  10b. County	17	own or Locatio	n '	5	4+19,19	30 /	10d. Inside City Limits
	death with the Maryland ms 23e or 28a-1 show I must be rollined at	Director	10e. Street and Number			M. Zip Code		10g. C	itizen of What C	1 No 2 No country?
36		y Funerai Director	11. Marital Status 1 □ Never Married 2 □ Married	12. Was Decedent Ever in U.S. Armed Forces? 1		Decedent of Hispar i, specify Cuban, Mi	/23/ nic Origin? (Specific exican, Puerto Rice pecify:	y Yes or No- can, etc.)	14. Race - Am Black, Whi	erican Indian, ite, etc.
21215-0036	within 72 hours after ene. then "neturel", or Ite	Completed by	3 ∰Widowed 4 □ Divorced  15. Decedent's Edu (Specify only highest grad  Elementary/Secondary (0-12)	Year or Dates:	Sa. Decedent's	Usual Occupation of work done during OT use retired)		16b. I	Specify: C	White Mindustry
	d be filed wil antal Hygien sed other th c svent, the	Be	17. Father's Name (First, Middle, Last)	. 1	2205	18.		First, Middle, Maide		N HOME
, Maryland	it. Pages 1 and 2 should b rtment of Health and Ments rtent: If item 27 Is marked njury or other treumatic s	To	19a. Informant's Name/Relationship (Ty Patrick James Garre	H/John J. Schozak	9b. Mailing Ad $238$	dress (Street and N	Number or Rural F	loute Number, City	or Town, State,	Zip Code) R MD <sup>2/23</sup>
Baltimore,	permit. Pages 1 Deportment of Hi Importent: If iter any njury or oth		20a. Method of Disposition  1 Suburial 2 □ Cremation 3 □ F  1 □ Comparison 5 □ Other (Specify)  21. Signature of Funeral Service Licegs	St. S	TANIS	(Name of yor other place)	5-14	-2005 BA	ocation - City or	Town, State
Ba	permit. Deportr Importe any nji		23a. Part 1. Enter the disease, r c mpl	cations that caused the death. Do	Z		ONKIIN	9 87.1	BA/to.	MD 2/224  Approximate
	Pnysician /Medical		shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ne cause on each line.				FON		Interval Between Onset and Death
8760,	cate be executed by streaming physician and burial-transit sithe burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence).  Due to (or as a consequence).	e of):	RTER	Y Pa	FSEAS	Ε	2 YEARS
O. Box 6	The law requires that the death certifica tte has been signed by the attending ph page 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	3c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal dea 4 □ Pregnant at time of death 9 □ Unknown		pic pregnancy er (specify)			23d. Date of de Month	livery Day Year
rds, P.	w requires that been signed b should be deta	by	Part II. Other significant conditions cor	tributing to death but not resulting	in the underly	ring cause given in i	Part I.	23e. Did tobacco		o the cause of death?
Vital Records,		Completed						24a. Was an autopsy performed?	death?	utopsy findings available completion of cause of
Division of Vit	To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	ation: To Be	25. Was case referred to medical examiner?  1 Yes 2 No F  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	T	Outpatient 3( . Time of Injury	DOA Other: 4	280	theck only one)_ 5  Residence . Describe how inju		cify)
Divis	itel or Atts rs after dea al Directo	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, street, fa	actory, office	28f.	Location (Street as City or Town, State	nd Number or Re ∋)	ural Route Number,
	To the Hospitel or within 24 hours after To the Funeral Dir completely filled in	Medicai	one)	sician: To the best of my knowledger: On the basis of examination a and manner stated.	ge, death occu and/or investig	ation, in my opinion	n, death occurred a	at the time, date an	d place, and due	to the cause(s)
	<i>y</i>	~	29b. Signature and title of Contrier	MD		RES -		29d. Da	te signed (Mont	2005
	ان			nD POBOXIIO TOU	UER 3	TOHNS HO		PETAL B	ALTIMON	21287
	Sta Registr		31. Date filed (Month, Day, Year) MAY 1 2 2005	7. Registrar's Signature	Sneeth	,	,	,		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Wonth Year 8.09A-M Caleb Bennie Sandifer 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sinou Baltimor Hesti al If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 3 M 2 □ F Yrs. Michigan Director 376-24-2709 May 30, 1930 74 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-1 show event, the Medical Examiner past be notified at 1 Yes 2 No Director Md. Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3419 Tulsa Rd 21207 USA or iteme 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 □ Never Married 2 1 Married altimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify. Black þ 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) SSA Elementary/Secondary (0-12) College (1-4or 5+) Equal Opportunity Specialist 12 permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 is marked oth any luly or other traumatic event 20cg. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Dolley B. James Bennie Sandifer 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3419 Tulsa Road Baltimore, Md. 21207 Jean F. Sandifer 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 05/17/05 Owings Mills, Md. \* 4 ☐Donation 5 ☐ Other (Specify) Garrison Forest Veterans Cemetery of Funeral Service Licenses 22. Name and Address of Facility Estep Brothers Funeral Service 1300 Eutaw Place Baltimore, Maryland 21217 23a. Part 1. Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tenoschochic Immediate Cause (Final vancular **Physician** orp stand disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated deept). Due to (or as a consequence of): Examine The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) P.O. □Yes 2□No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 Probably 4 Donknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 2 TONO 1 Tyes 2 No or Attending Physician: To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) examine 1 Yes Hospital: Other: 2 □ No 1 Inpatient ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Division 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No I Director: / 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide To the Hospitai within 24 hours a To the Funerel I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0021730 lam (1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State 1 2 2005 Registrar

			1 - For State Registrar	State of Maryland / Depa Cer	artment of Health and I rtificate of Death		ene g. No. 2005	6
	Physici /Medi	cal	Decedent's Name (First, Middle, Last)     EVELYN STYLES			2. Date of Death Month	Day Year	3. Time of Death 9:30 A M
	Examir Funeral Director	ner	4a. Facility Name (If not institution, give street HAVEN NURSING HOSSING HOSSING Security Number 10 Security Number 10 Security Number 10 Miles Not Not Not Number 10 Miles Not Not Number 10 Miles Number		Ab. City, Town, or Location of Death  BALTIMORE  If Under 1 Year   If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, ) 9/8/19	4c. County of Death  9. Birthp  Cour  M	lace (State or Foreign
		tor	Usual Residence of Decedent  10a. State 10b. County  MD N/A	10c. City, Town or Lo		19/0/19		0d. Inside City Limits 11 Y Yes 2 □ No
Maryland 21215-0036	nd 2 should be filled within 72 hours after death with the Maryland the and Mental Hyglene.  27 Is marked other than "neturel", or Items 23e or 28e-f show traumatic event, the Medical Examinar must be restliked at	To Be Completed by Funeral Director	1 Never Married 2 Married  3 Widowed 4 Divorced  15 Decedent's Educat (Specify only highest grade of Elementary/Secondary (0-12)  10  17. Father's Name (First, Middle, Last) WILL LARKINS  19a. Informant's Name/Relationship (Type,	Was Decedent Ever in U.S. Amed Forces? 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		coecify Yes or No- co Rican, etc.)  king  ne (First, Middle, Ma  A. HARR	HOME  aiden Sumame)  RIS  City or Town, State, Zip	an Indian, etc. ACK dustry
Baltimore,	parmit. Pages 1 and 3 Department of Health Important: If item 27 any injury or other tr. once.		20a. Method of Disposition  1 Burial 2 Cremation 3 Rem  4 Donation 5 Other (Specify)  21. Signature of pure all Service Licensee	oval from State 20b. Place of Disposor Campilary Crem	sition (Name of particles) CREMATORY 5/9 ESTEP Address Sacility UNI	Date 20 / 05 C ERAL HOM	CATONSVILI	
8760, <	death certificate be executed  Wedgeal  Water and for use as the burial-transit	dical Examiner	23a. Part i Enter the disease, or complicat shock, or heart failure. List only one of limediate Cause (Final disease or condition resulting in dealh)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d	ions that cause the death. Do not enter ause on each ine.	BOO EUTAW DI. B. er the mode of dying, such as cardiac  NE DF CEF  CVACCULAN  Amail F  CRF  C	or respiratory arrest	EASE	Approximate Interval Between Onset and Death
P.O. Box 68	that the death certifice and by the attending ph detached for use as t	Physician/Med	in the past 12 months?		Ectopic pregnancy Other (specify)		23d. Date of deliver	ry Day Year
Records,	law requires as been sign 2 should be	Completed by Ph	Part II. Other significant conditions contrib	uting to death but not resulting in the un Refin alen The CR	nderlying eause given in Part I.  WHITE STATES AND THE STATES AND	1 Tes  24a. Was an autopsy performer	d? prior to come death?	
	ktending Physician: The death. ctor: After this certificate y the funeral director, pag	Certification: To Be	2 ☐ Accident investigation	ital: 1 Inpatient 2 ER/Outpatient 8a. Date of Injury (Month, Day Year)  28b. Time of Injury	Cther: Sing Ho	h (Check only one)	e 6 □Other (Specify,	
Divi	To the Hospitel or Attending Physician: The within 24 hours after death.  To the Funerel Director: After this certificate his completely filled in by the funeral director, page	Medical Certific	29a. Certifier 1 Certifying Physicia	8e. Place of Injury - At home, farm, stre building, etc. (Specify)  an: To the best of my knowledge, death On the basis of examination and/or invand manner stated.	Occurred at the time, date and place	and due to the caus	se(s) and manner as sta and place, and due to Date signed (Month) D	ted. the cause(s)
	Star Registra	7.0	30. Name and address of person who complete the state of	eted cause of death (Item 23a) (Type of 1997)  32. Registrar's Signatur	D3/90 2431 MAR	24(ANI)	Ave vone, my	12/2/8

			For State Registrar		State o	of Man	yland /		rtmen <i>tificat</i>				ental Hy	/giene Reg. No	6 U U	5	1611	5
	Physicia	ın	Decedent's Name (First, Mi	ddle, Lasi		mice	B. Si	mma	ons		_		2. Date of D Month MAY	eath Da	y y 2005	ear 11	3. Time of Death :45 P	
	/Medic Examin		4a. Facility Name (If not institu	tion, give						Town, or	Location	of Death	<u>riai</u>		. County of			
	Ladiiii		GREATER BALTIMORE							SON	- Williams	O d Libro			BALTIMO		(0)	
	Funeral		5. Social Security Number 212-28-0469	6. Se	x ⊒M2K∏F	7. Age (i	In <i>yr</i> s. last i 75	Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Bi (Month, D	irth la <i>y, Year,</i> <b>6. 192</b>	9	Country	e (State or Forei ) Md.	<i>g</i> n
	Director		Usual Residence of Decedent											0, 102				
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	ath with	rai D	2818 Gatehouse	Drive							212					U.S.A.	1. 0	
9	1 and 2 should be filed within 72 hours after death with the Marylan Fleath and Mantal Hygiene. I Heath and Mantal Hygiene. Items 27 is marked other than "netural", or Items 23a or 28e-f show other traumatic event, I'm Madical Examinet must be notified at	Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ I	Married	12. Was Dec Armed F 1  Yes	orces? 2∏xNo	er in U.S.	1	Was Deced f Yes, sped i ☐ Yes		ispanic Or un, Mexica Specify:		cify Yes or N Rican, etc.)	0-	14. Race - Black, Specify:	White, etc		
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			23a. Part1. Enter the disease shock, or heart failure.	o, or comp	olications that	caused the	e death. D	o not ent	er the mod	le of dyin	ng, such as	cardiac o	r respiratory	arrest,	10 2 12 1	A In	pproximate iterval Between inset and Death	
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	3	0	30. Name and address of pe	mon	completed ca	Use of dea	ath (Item 23	Sa) (Type,	Print)	209	1	im	onium	, ,	n1)	2	1093	
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State of Maryland / Department of Health and Mental Hygiene

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	Dhysici	200	1. Decedent's Name (First, Middle, Last	)			-		2. Date of De Month	eeth Day Year	3. Time of Death
200	Physici /Medi		ALBERT	SCHAU	B				MAY	09 2009	5.30PM
-15	Examir	ier	4a Facility Name (If not institution, give					•	Location of Deat	,,,	
_			BRIGHTWOOD CENTE  5. Social Security Number 6. Se				er 1 Year	LUTHERV		BALTIMO	
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	ylend		10a. State 10b. County	1	Oc. City, Town	n or Location					10d. Inside City Limits
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	or 28	- Fe	10e. Street and Number			10f. Zi	p Code			10g. Citizen of Whet C	Country?
	ath w	ral	214 KUETHE ROAD				21	.060		US	SA
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5-0	72 h	etec	15. Decedent's Edu (Specify only highest grad	cation e completed)	16a.	Decedent's Usu	al Occupe	etion during most of we	orkina	16b. Kind of Busines	s/Industry
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d 2	filed with Hygiene. other than		12 17. Father's Name (First, Middle, Last)		C.	HIEF MAG	PHTNI		mo /First Middle	NEWSPAPEI	Κ
Maryland	Wentel I Mentel I arked of artic eve	o Be	GEORGE SCHAUB					ANNA S'		Maiden Sumame)	
Z	2 should be end Mentel is marked o	۲	19a. Informant's Name/Relationship (T)	rne Print)	19h	Mailing Addres	s (Street s			er, City or Town, Stete,	Zin Cada)
	and 2 ;	-	MRS. ROBIN VAUGHN						EONIX, M	-	2.lp C00e)
ē,	s 1 and if Health item 27 other tr	Ì	20a. Method of Disposition		20b. Place of	Disposition (Na	me of	1	Date	20c. Location - City o	r Town, State
E	Page ento nt: if		VXBurial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		HAVEN MI	,	1	5/13/05	GLEN BURN	ITE. MD
Baltimore,	permit. Pages 1 and 2 should be filed within Depertment of Health end Mentel hygiene. Important: If item 27 is marked other than any injury or other traumant event, the Medie.		21. Signature of Funeral Service Licens	POUNLY MO		22. Name a	nd Addres	s of Facility	SINGLETO	N FUNERAL H BURNIE, MD	
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	Physician		Story of House Indiana. Elst only of	io cause on escar line.							Onset and Death
	/Medical Examiner		Immediate Cause (Final disease or condition	CON	GES	TIVE	he	EARY	FAILUR	RE	DAYS
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	lew requires that the death certificate be assocuted as been signed by the attanding physician and 2 should be dateched for use as the bunal-frensit	xar	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Du	e to (or es a c	onsequence of):					
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68	rtificat ng phy es th	8	resulting in death) Last	Due	e to (or as a co	onsequence of):					
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	deat de att	Physician/M	Part II. Other significant conditions con	tributing to death but n	ot resulting in	the underlying of	ause give	n in Part I.	23b. Did (	obacco use contribut	e to the cause of death?
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<b>\frac{1}{2}</b>	Physician: The lew this certificete has t eral director, pege 2 s	- □	25. Was case referred to medical examiner?	ospital:			Othe		ath (Check only o		
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É	il or Attending efter death. I Director: Atte d in by tha fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (S	- At home, far Specify)	m, street, factory	y, office		28f. Location (S City or Tow	Street and Number or R m, Stete)	ural Route Number,
	To the Hospital or Attending Physician: The is within 24 hours efter death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, pege		29a. Certifier (Check only one) 2 Medical Examin	iclan: To the best of m er: On the basis of exa end manner steted	y knowledge, amination and	death occurred /or investigation	et the time , in my op	e, date end place inion, death occu	e, end due to the d arred at the time, d	cause(s) end manner a date and place, and du	s stated. e to the cause(s)
	With:		29b. Signature and title of certifier			290	c. License	number		29d. Date signed (Moni	th, Day, Year)
			> Spuple M	D		D	00	53150		MAYO	2005
			30. Name and address of person who co	npleted cause of death	(Item 23a) (T	Type, Print)			0 = 1	WTHE	ERVILLE
	1,3		SHALLON MALA	COUPTA 1	40,5	51532	164	TFIELD	104	), ~	D 21093
	Stat Registra	e	30. Name and address of person who con Sin Area N M A A 31. Date filed (Month, Day, Year)  MAY 1 2 200	32 Registrer's	Signature	Sperte					

							ental Hygier	Property on the	16117
		Physic /Medi Examir	cal	1. Decedent's Name (First, Middle, Last)  Andrew Edward Schwarz  4a. Facility Name (If not institution, give street and number)  100 Wakely Terrace	4b. City, Town, Bel A	or Location of Death	May 9, 2	Day Year 005 4c. County of Dea Harfor	
		Funeral Director		5. Social Security Number 215-30-6387 6. Sex 7. Age (In yrs. last birthda 73 Yrs.	y) If Under 1 Year Months Days	s Hours Min.	8. Date of Birth (Month, Day, Yea		thplace (State or Foreign ountry) ryland
3		filed within 72 hours after death with the Maryland Hygiene. Idhar than "natural" or Itams 23a or 28a-f show int, the Medical Exart at must be notified at	rector	10a. State 10b. County 10c. City, Town or	Location  L Air  10f. Zip Code		100.0	Citizen of What C	10d. Inside City Limits 1 ☐ Yes 2 ☑ No
SCHUMARKE		ours after death with al', or Itams 23a or Exametra must be	Funeral Director	100 Wakely Terrace  11. Marital Status 12. Was Decedent Ever in U.S. 13	21	.014		USA	
Seh	5-0036	72 hours after "natural", or Ita	by	1 Never Married 2 Married 1 Tyres 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ No			Black, Whi	hite
	21215-	d within 72 ho giene. ar than "natur . The Medical	Completed	(Specify only highest grade completed) (Giv Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occu re kind of work done DO NOT use retire nt Manage	e during most of workin ed)	g	Kind of Business	,
	Maryland	e d la la	To Be C	17. Father's Name (First, Middle, Last) Albert Andrew Schwarz		Catherin	(First, Middle, Maide e Ann Rus	sell	
		ges 1 and 2 should t of Health and Mer If itam 27 is marka or othar traumatic		Geraldine A. Schwarz/Wife 100	Wakely T	errace, Be	l Air, MD	21014	
hen	Baltimore,	t. Pa rtmen rtant: njury		'4 Donation 5 Other (Specify) Highview		lens   5-12-		Location - City or 11ston,	
An	Ba	Depa Impo any ii		Mab T. 2	50 W. Br	Funeral Ho oadway Str	eet, Rel	Air, MD	21014
		Physician /Medical	80. J	23a. Part1. Enter the disease of amplications that caused the death. Do not enshock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):	r	mg, soon as caldiac of	respiratory arrest,		Approximate Interval Between Onset and Death
	8760,	or Attending Physician: The law requires that the death certificate be executed the death certificate be executed by the death certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit.	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):	nemzą				3 years
	.O. Box 6	that the death certific ed by the attending p detached for use as	Physician/Medical		□Ectopic pregnanc □ Other (specify) _	Sy		23d. Date of del Month	very Day Year
	ords, P	w requires that been signed to should be det	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause giv	ven in Part I.		1	the cause of death?
	al Reco	ician: The law r certificate has be rector, page 2 sh	Completed				24a. Was an autopsy performed?	prior to death?	topsy findings available completion of cause of
	Division of Vital Records, P.O. Box	To the Hospital or Attending Physician: The la within 24 burus after death.  To the Funaral Director: After this certificate has completely filled in by the funeral director, page 2	atlon; To Be	25. Was case referred to medical examiner?  1   Yes   2   No	of 28c. Injur Wor	26. Place of Death ( her: 4 Nursing Home ry at 28 rk? Yes 2 No		6 □Other (Specury occurred	sify)
	Divis	ital or Attend irs after death ral Diractor: led in by the f	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)			f. Location (Street a City or Town, State	Θ)	
		To the Hospital within 24 hours a To the Funaral I completely filled	ledical	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, deal one)  Medical Examiner: On the basis of examination and/or in and manner stated.	ivestigation, in my o	opinion, death occurred	at the time, date an	d place, and due	to the cause(s)
		P S D S D	M	29b. Signature any title of certifier  Cuttuful  30. Name and address of person why impleted cause of death (Item 23a) (Type,  Wm CW4762F1EU MD 9/03 F3  31. Date filed (Month, Day, Year)  MAY 12 2005  32. Degistrar's Signature	29c. Licens	se number	29d. Da	ate signed (Month	Day, Year)
		611		JU. Name and address of person why impleted cause of death (Item 23a) (Type, Wm C WATERFIELD WD 9/U3 F.	ronkler Sg	from De 1	Boltimon,	MD 21	237
		Sta Registra	ar	MAY 1 2 2005 Segue & B	code				

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Dav Month Year **Physician** May 7, Dorothy L. Scully 2005 5:10 AM /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Oak Crest Village Baltimore Baltimore If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Funeral Months Days 1 ☐ M 2 □XF Director 215-10-4714 91 May 2, 1914 Maryland Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Deperment of Health and Mental Hygiene. mportent: if item 27 is marked other than "naturel", or items 23e or 28a-1 show any injury or other treumstic event, the Medical Examiner must be notified at 1 ☐ Yes 2√2 No Director Maryland Baltimore Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 8830 Walther Blvd. 21234 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married ☐ Yes 2 No Yes, Give 1 ☐ Yes 2 ➡ No Specify: Completed by Specify: 3 Widowed 4 □ Divorced Year or Dates: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Executive Secretary Insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Maryland Be 1 and 2 should be Richard James Lucas Hildegarde S. Hartmaier ဂ္ 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mary D. Deyesu / Daughter 67 Crystal Court, Bel Air, MD 21014 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Peges 1 Depertment of H 152 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) New Cathedral Cemetery 5-11-05 Baltimore, Maryland 21. Signature of Fund LService Licen 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 nter in disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Disease Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated experies end Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): resulting in death) Last 23b. Did tobasco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2□ No 3 ☐ Probably 4 ☐ Unknown Ś 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 s 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No certificate Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Universing Home 5 Pesidence 6 Other (Specify) ၉ 1 ☐ Yes 2□ No funeral 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Watural 1 ☐ Yes 2 ☐ No

or Attending Physician: The law requires thet the death certificate be executed ours efter death. nerel Director: Af filled in by the fu within 24 hours e To the Funerel C completely filled Hospital

Certification: 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

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31. Date filed (Month, Day, Year

			State of Mai 1- State RegistaMEND ITEM #11&19a	-		ealth and Me		ene 005	6119
	Physici		1. Decedent's Name (First, Middle, Last)  OSEPH  SER4F		<b>XX</b> 13	2	2. Date of Death Month	Day Year	3. Time of Death G 15 PM
	/Medic Examin		4a. Facility Name (If not institution, give street and number)  HERLY (1059, TAL)			Location of Death		4c. County of Death	A
	Funeral Director		216-24-9614 15 <sup>M</sup> 20F	(In yrs. last birthday) 76 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. 8 Hours Min.	B. Date of Birth (Month, Day, Y March 5	(ear) 9. Birth Cou. 1929 Mar	place (State or Foreign http) yland
	aryland show	١	Usual Residence of Decedent  10a. State 10b. County  MD N/A	10c. City, Town or Lo	ocation 1timore C	itv			10d. Inside City Limits
	th the Ma or 28a-f e coullis	Director	10e. Street and Number		10f. Zip Code		10g	g. Citizen of What Cou	
	e 23a o	erai [	311 S. Exeter Street  11 Marital Status 12. Was Decedent Ex	verin U.S. 13 V		1202	ifv Yes or No-	U.S.A	
36	be filed within 72 hours after death with the Maryland stal Hyglene.  de other than "naturel", or lieme 23a or 28a-f show event, the Medical Exam and must be notified at	by Funeral	11. Marital Status  1 □ Never Married  2 ☑ Married  1 □ Yes 2 □ No If Yes, Give  Year or Dates:	)	If Yes, specify Cuba 1 ☐ Yes 2 1 No	spanic Origin? (Spec n, Mexican, Puerto Ri Specify:	ican, etc.)	Black, White, Specify: Wh	etc.
2-00	"nature	eted	15. Decedent's Education (Specify only highest grade completed)	16a. Dece (Give	dent's Usual Occupa	ation during most of working	7	6b. Kind of Business/Ir	dustry
2121	filed withln Hygiene. Ither than	Completed	Elementary/Secondary (0-12) College (1-4or 5+	)	avern Own			Liqour	
and	e d fa	Be	17. Father's Name (First, Middle, Last) Pietro Serafini			18. Mother's Name (			
Maryland 21215-0036	d 2 should th and Mer 7 is marke traumatic	P.	19a. Informant's Name/Relationship (Type, Print) Anna Marie Serafini	( <b>IFE</b> ) 196. Mailin 31	ng Address (Street a		Route Number, (	City or Town, State, Zi, Omre, MD 2	0 Code) 1202
Baltimore, I	permit. Pages 1 and 2 should Department of Health and Men Important: if Item 27 is marke any injury or other traumatic once.	i	20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Disponsion Sacred H	osition (Name of matory or other place eart of J	esus Cem 5	te 20 5/10/05	Dc. Location - City or T Baltimore,	own, State MD 21224
Baltii	permit, Pag Department Important: I any injury o		21. Sign to of Funeral Service Licensee	, C.	Name and Address harles S. 224 Easte	ss of Facility Zeiler & rn Avenue	Son In Baltim	c. ore, MD 21	224
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.O. Box 687	ie death certificate the attending phy. hed for use as the	by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown   9   Unknown   23c. If yes, outcome of 1   Live birth 2   4   Pregnant at to 9   Unknown   9   Unknown   9   Unknown   9   Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of deliv Month	ery Day Year
<u>α</u>	uires that the signed by Id be detact	d by Ph	Part II. Other significant conditions contributing to death but ASD vahor Dreward.		ınderlying cause gıv	en in Part I.		cco use contribute to	the cause of death?
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Vital	Physician: this certificatal director, it	Be	25. Was case referred to medical examiner?		at 35 DOA Cth	26. Place of Death			4.1
of	ding Physician: The I h. After this certificate ha funeral director, page	on; To	27. Manner of Death 28a. Date of hour		111 3 00 00 A	4 Indising Hom	8d. Describe how	ce 6 Other (Spec vinjury occurred	<i>'y</i> )
Division	l or Attending after death. Director: After I in by the fune	Certification:	2 Accident investigation	ry - At home, farm, st		Yes 2 □No	8f. Location (Stre City or Town,	eet and Number or Rui State)	al Route Number,
۵	Hospita 4 hours Funerei	edical Ce	29a. Certifier (Check only one) (Check only one)	examination and/or in					
	To the within 2 To the comple	Me	29b. Signature and title of certifier  Cosin A	ე	29c. Licens	e number 42637	290	d. Date signed (Month	
	1		30. Name and address Terson who completed cause of de		Print) ST. PAUL	L PLACE	BATT	MORE, MD	
	St Regist	ate rar		r's Signature	barte				
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			For State Registrar	Sta	ate of M	faryland i			of Hea of De		lental Hy	giene Reg. No.	05	6120	)
Phy	/sicia	200	1. Decedent's Name (First, Middle	, Last)							2. Date of Dea Month	Day	Year	3. Time of Death	
	ledic		Sarah Thorne			-l		4b Ciby T	own or Loo	nation of Death	05	10.00	200.		-M
Exa	amin	ęr	4a. Facility Name (If not institution GOOD SAMAR)	-		PITAL		40. City, 1		MORIE		40.00	runty or Dea	ui	
- Francisco			5. Social Security Number	6. Sex		ge (In yrs. last	birthday)	If Under	Year If	Under 24 Hrs.	8. Date of Birt	h ,	9. Bir	thplace (State or Fore	ejan
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pu ,			Usual Residence of Decedent			10c. City, To	our or la	antion						10d, Inside City Lim	nite
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the Ma		Director	10e. Street and Number				Dare	10f. Zip (				10g. Citizer	n of What C		
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or y failed & L. C.	9	Funeral	11. Marital Status	12. W	as Deceder	nt Ever in U.S.	13. V	Vas Decede	ent of Hispan	nic Origin? (Sp	ecify Yes or No- Rican, etc.)	14.	Race - Am Black, Whi	erican Indian,	
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2 short and his ma	Buma		19a. Informant's Name/Relations	hip (Type, P	rint)			-			a <i>l R</i> oute Numbe			Zip Code)	
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permit, Pages 1 and 2 should Department of Health and Men Importent: If item 27 is marke	ıry or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation '4 ☐ Donation 5 📉 Other (S		val from Stat Ln sta	cemi	e of Dispo etery, cren	sition (Nam natory or oti	e or her place)	0 0 0 0	Date	20c. Loca	tion - City of	Town, State	
permit. Departr Importe	any inju		21. Signature of Fineral Service Rona I d	Licensee S. Wad	e A Di	ector			Address of natom re, M		1 <sup>655</sup> W.	Balt	imore	Street	
			23a. Part 1 Enter the disease, or shock, or heart failure. List	complication	ns that caus	ed the death. I	Do not ent	er the mode	of dying, su	uch as cardiac	or respiratory ar	rest,		Approximate Interval Between	
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/Med Exami			resulting in death)		Due to (or a	as a consequen	nce of):			CENTRAL .	~	0		EEW ONE	997
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e dea	ped fo	/sici	1 ☐ Yes 2 No 9 ☐ Unknown		□Pregnant □Unknown	at time of deatl	h 5□	Other (spe	ecify)					,	
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ysicii	direc	o B	examiner? 1 ☐ Yes 2 No	Hospit	tal: 1 Inpa	atient 2 ER	VOutpatier	t 3 DO	A Other:	4 Nursing Ho	ome 5 Resid	dence 6	Other (Spe	ecify)	
ng Phy ter thi	by the funeral director, page	J: T	27. Manner of Death  1 Natural 5 Pendi		la. Date of I	njury 28 Day Year) 28	3b. Time of Injury	28	Bc. Injury at Work?		28d. Describe I	now injury o	ccurred		
tending death. tor: Afte	the fu	catle	2 Accident invest	gation				М		2 🗆 No					
or Att	n by 1	Certification:	3 Suicide 6 Could 4 Homicide determ			Injury - At home etc. (Specify)	e, farm, str	eet, factory	, office		City or Tov		vumber or F	lural Route Number,	
pitel o	pelli		29a. Certifier 1 X Certifyi	na Physician	To the be	et of my knowle	adae deatl	a occurred :	at the time	date and place	and due to the	cause/s) ar	nd manner a	s stated	-
To the Hospitel or Attending Phys within 24 hours after death.  To the Funeral Director: After this.	completely filled in	edical		Examiner: (		s of examination								e to the cause(s)	
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		T ICUX	State of Ma		d / Depa			ealth a	and M	ental Hy	giene		
		1 - For State Registrar		•		tificate					Reg. No.	15	16   2
Physici	ian	1. Decedent's Name (First, Middle,								2. Date of De Month	Day	Year	3. Time of Death
/Medi		Robert H. 7				4h Cihi	Tour or	Location of	of Dooth	May	11, 20	005	9:30 A M
Examir	ner	4a. Facility Name (If not institution, Charlestown	give street and number) 1 Care Cente	r				nsvi]			Balti		
Funeral			6. Sex 7. Ag	-	last birthday)	If Under Months		If Under Hours		8. Date of Bir	th	9. Birthi	place (State or Foreign
Director		219-34-9919	<b>™</b> 2□ F	74	Yrs.	- Inditing	54,5	,,,,,,,		Jan. 3	, 1931	_Afr	ntry) ica
land Sw		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits
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ter de	Fun	11. Marital Status 1 ☐ Never Married 2 ☐ Marri	Armed Forces?							cify Yes or No Rican, etc.)	Blac	ck, White,	, etc.
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72 hc	Completed	15. Decedent (Specify only highes			16a. Deced	dent's Usua kind of wo DO NOT us	l Occupa rk done d	ation luring mos	it of worki	ng	16b. Kind of Bi	usiness/In	ndustry
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If e) INTAINITY INTERPLICATION STATES INTERPLICATION STANDS STAND	Be Co	17. Father's Name (First, Middle, I	_ast)			-		18. Mothe	er's Name	(First, Middle	, Maiden Suman	10)	
Viand ould be file Mental Hy arked oth	TO E	Joseph I. Touch	nette							Frixon	-		
2 sho		19a. Informant's Name/Relationsh									er, City or Town,		p Code)
E, R 1 and 1 and Health em 27 ther t		Joan Lee Touche 20a. Method of Disposition	ette, Daugnt	20h B	Place of Dieno	eition (Nar	na of	1		town, I	RI 02842 20c. Location -		own, State
ages ant of at: If it		1 ⊠ Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (Sp	3 Removal from State	Но	Gate aven C	Of	ther plac	9)	)5/13	/05	Silver	Stri	ng. MD
Dallinore, permit. Pages 1 an Department of Heal Importent: If item 2 any injury or other once.				11100	22	2. Name an	d Addres	s of Facilit	ty I LI	ma D A			
		21. Signature of Funeral Service L	or o			301 F	rede	rick	Road	Catons	sville,	Mary	land 21228
		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caused only one cause on each li	the death	h. Do not ent	er the mod	e of dyin	g, such as	cardiac o	r respiratory a	rrest,		Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	aDue to (or as		NEUR	ronsif	7					-	20A45
Examiner			Due to (or as	a conseq	derice cry.							1	
p =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a conseq	uence of):								
ecute and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	a conseq	uence of):								
F.C. BOX 88/00, that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	calE		l d		,								
certificate nding phy use as the													
ath cer tendir	lan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 Feta	I death 3	Ectopic p						te of deliv	rery Day Year
ords, F.C. BC requires that the death een signed by the atter hould be detached for t	Physici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at 9☐ Unknown	time of d	leath 5L	Other (sp	өспу)						
	by Ph	Part II. Other significant condition	1. 4		-		ause give	an in Part I	l.	23e. Did t	tobacco use cont	ribute to t	the cause of death?
ecords law requires as been sign 2 should be	leted b	LEFT	HEMISPHER	10	TROK	E.				10	Yes 2□No	3 Prof	bably 4 Unknown
	plet									24a. Was	DSV /	prior to co	opsy findings available ompletion of cause of
VICAI MEC sicien: The law s certificate has b lirector, page 2 s	Compl									1 ☐ Yes	2/2] No	death? 1 🗌 Yes	2□ No
Of VITAL Physicien: 1 rthis certifical ral director, p	o Be	25. Was case referred to medical examiner?	Hospital:		ER/Outpatier		Othe			n (Check only o	one) dence 6 ⊡Oth	er (Sneci	(fy)
Phy Phy al	<del> </del>	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date of Inju	iry	28b. Time o		8c. Injury Work		-		how injury occur		<i>(y)</i>
Attending I r death. ector: After by the funer	atlo	1 Natural 5 Pendin investig	ation	y 16a1)	Injury	М		Yes 2□	No				
OIVISION  or Attending after death. Director: After in by the fune	Certification:	3 Suicide 6 Could r 4 Homicide determ	ined 28e. Place of Inj building, et	ury - At he c. (Specif	ome, farm, sti y)	eet, factor	, office			28f. Location ( City or To	Street and Numb wn, State)	er or Rur	al Route Number,
spitel ours a nerel C		29a. Certifier Certifyin	g Physicien: To the best	of my kno	owledge, deat	h occurred	at the tim	ne, date ar	nd place,	and due to the	cause(s) and ma	anner as :	stated.
To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funerel	edical	(Check only 2 Medicel one)	Exeminer: On the basis o and manner st	f examina	ition and/or in	vestigation	, in my o <sub>l</sub>	oinion, dea	ath occurr	ed at the time,	date and place,	and due t	to the cause(s)
To the To the Complex	Σ	29b. Signature and little of certifier	- 11 -					number	4		29d. Date signe		
.m.		Mus	/ Van 6	donth (lta-	7 , D ,	Print)	レナ	7 /		0	I LAY /	11	2002
12		30. Name and address of person	Who completed cause of a	Jean (Iten	7// A	1A11	EN	CHO	DICE	CANO	EATO	NSV	2005 (ILLE, MD
	ate	31. Date filed (Month, Day, Year)	32. Registr	ar's Signa	ature		,						7
Regist	trar		MAY 1 2 2005	Ele	ر مودد	K A	mark	-					

Arnold Watson 05-03161 NJM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of M	aryland			nt of H <i>te of L</i>				giene Reg. No		*	6122
	S		Decedent's Name (First, Middle, Las	t)							2. Date of De Month	ath Da	y Yea		3. Time of Death
	Physici: /Medic	al		Arnold		gene	Wats				May	6	200	_	2013 <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, give		)			, Town, or $1\mathtt{time}$		of Death			County of De		24 + 4 + 4
			Maryland General  5. Social Security Number 6. Se		ge (In yrs. la	ast birthday)	If Und	er 1 Year	If Under	24 Hrs.	8. Date of Bir	th	Baltimo 9.8		e (State or Foreign
	Funeral Director			ДM 2□F	52	Yrs.	Month	Days	Hours	Min.	8. Date of Bir (Month, Da 1-20	-195	3	Country,	Md
	p.		Usual Residence of Decedent		100 City	, Town or Lo	- antion							104	Inside City Limits
	ehow	5	10a. State 10b. County Md	N/A			Jeation							100.	Yes 2 No
	the M	Director	10e. Street and Number		Ва	alto	10f. Z	ip Code				10g. Cit	izen of What	Country	?
	3a or		1342 W. North Aver	nue				21217	,			υ	SA		
	death	Funeral	11. Marital Status	12. Was Decedent Armed Forces		S. 13.	Was Dec	edent of Hi	spanic Or	igin? (Spec	cify Yes or No Rican, etc.)	)-	14. Race - Ar Black, Wi		
9	or ite		1 Never Married 2 Married	1 ☐XYes 2 ☐ If Yes, Give				2 <b>X</b> No	Specify:				0	lacl	
21215-0036	4 within 72 hours after death with the Maryland jiene. r than "natural", or items 23a or 28e-f ehow the Medical Esaminet must be medified at	Completed by	3 ☐ Widowed 4 X Divorced  15. Decedent's Ed	Year or Dates:	1	16a, Dece	dent's Us	ual Occup	ation			16b. K	ind of Busine		
7.	- 69	plet	(Specify only highest gra	de completed)  College (1-4or	5+1	(Give	kind of		during mos	t of workin	g				Service
212	illed within I Hygiene. other then rent, the Me.	E O	9th grade		N/A	Sanit	atio	n Wor							··
nd	be filed tal Hygie d other event, the	Be	17. Father's Name (First, Middle, Last)								(First, Middle		Sumame)		
yla		은	Jesse F. Watson	5		10h Mail	- A dele	(Stroot			L. Bar		or Town, State	Zio Co	odol
Maryland	d 2 sh h and 7 is m traum		19a. Informant's Name/Relationship ( Linnea R. Watson		er						Balto,			s, 21p 00	J08)
a)	ges 1 and 2 should t of Health and Mer If item 27 is marks or other traumatic		20a. Method of Disposition		20b. Pl	lace of Dispo	osition (A	ame of	al la	Da	ate	20c. L	ocation - City	or Town	, State
Ō	Pages ent of nt: If it		1 XBurial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specify		9	Zion				5-13-	2005	La	ınsdown	, Mo	i
Baltimore,	permit. Pages Department of I Important: If ite any injury or of		21. Signatore of Funeral Service Licer		MIT	2	2. Name	and Addres			rch F/ h Aven		lest Salto,	Md 2	21215
			23a. Part 1. Enter the disease, or com stock, or heart failure. List only	plications that cause	d the death	n. Do not en	ter the m	ode of dyin	g, such as	cardiac or	respiratory a	rrest,		A	pproximate iterval Between
	Physician		Immediate Cause (Final disease or condition	Atha	COKALO	untir	Ca	diov	SELL	ar	Diseas	0,		0	nset and Death
	/Medical		resulting in death)	Due to (or a	s a consequ	uence of):		10	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		Die C				
Н	Examiner		Sequentially list conditions,	b. Due to (or a											
7	ed sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	s a consequ	ience oi):									
V	al-trar	xan	that initiated events resulting in death) Last	Due to (or a:	s a consequ	uence of):								1	
8760,	cate be executed physicien and the burial-transit	dical	(	d											
9	tificating phy	ledi												!	
Вох	The law requires that the death certificate be executed the has been signed by the attending physicien and tage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom- 1 ☐ Live birth	2 Fetal	death 3[		pregnancy					23d. Date of o	delivery Da	ay Year
В	the at	/sici	1 Yes 2 No	4□Pregnant a 9□Unknown	at time of de	eath 5[	Other	specify)							
<u>α</u> .	that the de led by the a detached t	Ph	Part II. Other significant conditions of	ontributing to death	but not resu	ulting in the u	underlyin	g cause giv	en in Part	1.	23e. Did	tobacco	use contribute	to the	cause of death?
ds,	uires tha	d by									1 🗆	Yes 2	<b>1</b> 0 No 3□	Probab	ly 4 □Unknown
Records,	w require s been si should b	Completed									24a. Was		24b. Were	autopsy	y findings available letion of cause of
Re	The lay te has	mo du									auto perf	ormed? 2 <b>V</b> No	death	?	□ No
Vital	(0 ===	BeC	25. Was case referred to medical						26. Plac	e of Death	(Check only	-1			
of V	Physicien: this certific ral director,	ToE	examiner? 1X Yes 2 No	Hospital: 1 Inpat	- 21	ER/Outpatie			4 🗆 IN				6 ☐Other (S	pecify)	
	ding Pl		27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of In (Month, D	jury lay Year)	28b. Time o Injury	of M	28c. Injur Wor	yat k? Yes 2.⊑		28d. Describe	how inju	ry occurred		
isio	ttendi death. stor: A r the fu	icat	2 Accident investigatio 3 Suicide 6 Could not b		niury - At ho	ome, farm, st			163 2		28f. Location	Street a	nd Number or	Rural F	Route Number,
Division	after Direction by	Certification:	4 Homicide determined	building,	etc. (Specify	y)	11001, 140	ory, omice			City or To				
_	pspite hours uneral	edicai C	29a. Certifier 1 Certifying Pt (Check only one)	nysician: To the bes	of examinat	wledge, dea tion and/or in	th occurr	ed at the tir on, in my o	ne, date a pinion, de	nd place, a ath occurre	and due to the	cause(s , date an	and manner d place, and c	as state	ed. ne cause(s)
	To the Howithin 24 To the Fu	Med	29b. Signature and title of certifier	and manner s	natou.			29c. Licens				29d. Da	ate signed (Mo	onth, Da	y, Year)
)	F ≯F 0		Vantate Ray	theil nu	)			O	CME			Мач	, 10, 2	2005	
	I		30. Name and address of person who	completed cause of	death (Item	1 23a) (Type	, Print)	1 D			D-7:	пау	<u>,</u> ,		21 201
	1			suther 1, x	no		11.	L Peni	n Str	eet	Baltin	ore.	, Maryl	and	Z1Z01
	Sta	ate rar	31. Date filed (Man Agy, Year) 20	05 Alegis	trar's Sign	ture	selle.	•							

		1 - For State Registrar	State of Mar		artment of He rtificate of D		F	Reg. No.	5 16123	
Physic	ian	Decedent's Name (First, Middle, Last)			. ~~~		2. Date of Dea Month	Day	3. Time of Death	
/Medi	cal	WILLIE 4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or Lo		MAY	4c. County o	005 7:42 AM	
Exami	ner	The Johns Ho	Okins Ho	spital	Baltino	a. 1	-4		N/A	
Funeral Director		5. Social Security Number 6. Sex	7. Age (	In yrs. last birthday 49 Yrs.	If Under 1 Year	f Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day Jan 11	h, Year) , 1956	9. Birthplace (State or Foreign Country) Wash.,D.C.	
and		Usual Residence of Decedent  10a. State 10b. County	1	0c. City, Town or L	ocation			10d. Insid		
Mary I-f sho	to	Md. N/.	Α		Balti	imore			1 Yes 2 □ No	
or 282	Direc	10e. Street and Number			10f. Zip Code	24249		10g. Citizen of W	nat Country?	
eath w	era	1525 Homestead Street	12. Was Decedent Eve	er in U.S. 13	Was Decedent of Hisp	21218	ecify Ves or No-		- American Indian,	
Definition (e.) Interpretable (and 12 to 13 to 13 to 13 to 15 to 1	by Funeral Director	1 X Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates:	31 11 3.3.	If Yes, specify Cuban,	Mexican, Puerto  Specify:	Rican, etc.)	, White, etc.  Black		
tithin 72 hours affile. In a natural, or headlest Exami	eted	15. Decedent's Edu (Specify only highest grad		(Give	dent's Usual Occupation	on ina most of work	ina	16b. Kind of Bus	iness/Industry	
Mithin ne.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired)  Mail C		,,,,g	Postal Service		
(filed wi Hygien other th		12 17. Father's Name (First, Middle, Last)					e (First, Middle,	Maiden Sumame	)	
should be fund Mental Is marked or umatic eve	To Be	Willie Wo	odard Sr				Mu	rl Woodard		
Malylailu nd 2 should be file lith and Mental Hy 27 is markad oth rtraumatic evant		19a. Informant's Name/Relationship (Ty Murt Woodard Mother	pe, Print)		ing Address (Street and				tate, Zip Code)	
s 1 and f Health itam 27 othar tr		20a. Method of Disposition	1	20b. Place of Disp	osition (Name of matory or other place)		Date	20c. Location - C	city or Town, State	
Page nent o ant: If ury or		1 <b>X</b> Burial 2 □ Cremation 3 □ F 1 1 1 2 □ Cremation 3 □ Cher (Specify)	emoval from State	44.4	s Family Cemete	ery	05/16/05	War	renton, N.C.	
parificacy permit. Pages 1 a Department of Hee Important: If itam any injury or otha		21. Signature of Funeral Service Licens	alker	2	2. Name and Address Estep Bro 1300 Euta	of Facility others Funel aw Place Ba	ral Service I	PA 121217		
Physician /Medical		23a. Part 1. Enter the disease, or compl shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	cations that caused the cause on each line.	e death. Do not en	ter the mode of dying,	such as cardiac	or respiratory ar	rest,	Approximate Interval Between Onset and Death	
ficate be executed licate be executed by sician and s the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to initional acuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a c						4 DAXS	
the death certi y the attending ched for use a	Physiclan/Medio	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 □ Live birth 2   4 □ Pregnant at tin 9 □ Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date Mont	,	
w requires that been signed b	þ	Part II. Other significant conditions con HUMAN IMMUNO	ntributing to death but		underlying cause given	in Part I.	23e. Did to		oute to the cause of death?    Probably 4   Unknown	
The law requires to the has been signed and be considered as the law and the constant of the c	Completed						24a. Was a autop perfor	sy pri mgd? de	ere autopsy findings available or to completion of cause of ath?	
Attanding Physician: The ridgall, and adding Physician: The ridgall, ector: After this certificate he by the funeral director, page	Be	25. Was case referred to medical examiner?	locaital:			6. Place of Deati		<del></del>		
2 g f a	): To	1 Ves 2 No 27. Manner of Death	lospital: Inpatient	2 ER/Outpatie	The second secon			ence 6 Other		
nding F ath. r: After e funer	atlor	Natural 5 Pending 2 Accident investigation	(Month, Day Y	'ear) Injury	of 28c. Injury a Work? M 1 ☐ Ye	s 2□No		. ,		
= 2 ± € =	Certification:	3 Suicide 4 Homicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Runch City or Town, State)								
a Hospital 124 hours a a Funaral (	edical (									
To tha within 2 To tha complet	Me	29b. Signature and title of certifier			29c. License n	umber	2	29d. Date signed	(Month, Day, Year)	
		MEDIAHAR , m	D		RESOC	0	r	nay le .	2005	
5		30. Name and address of person who co				pet Di	VIIIM~?	= MANA	MD 21287	
Ø	ate	MAPAM B.SHAPLANS 31. Date filed (Month, Day, Year)	32, Registrar's		WUGE 3	K-D=1, D	-UITTICKE	= IIJAKXU	1 arana arana	
Regist		MAY 1.2.2005	Alexa D.	H Ann	80					

			For State Registrar	State	of Marylar		artment of H			giene Reg. No: 0	)5	16124
			Decedent's Name (First, Middle	e, Last)					2. Date of De			3. Time of Death
	Physici	an	Lois	v	Llog t				Month May	Day 7 20	Year 005	1:30 AM
	/Medic		4a. Facility Name (If not institution	K.	West		4b. City, Town, or	Lanation of Dea		4c. County		1600 11
	Examin	ıer	,		,					40. County	OI Deali	
			5384 Harve 5. Social Security Number			10-4 5 i-45 -1	Colum If Under 1 Year		S   0 0 (B)		ward	
	Funeral		212-24-1416	6. Sex 1 ☐ M 2 🖾 F	7. Age (In yrs.	Yrs.	Months Days	Hours Mir	. (Month, Da	y, Year)	9. Birthpla	ace (State or Foreign ry)
	Director		Usual Residence of Decedent		77	113.			July 1	6, 1927	Mary]	Land
	and *		10a. State 10b. County		10c, Ci	ty, Town or Lo	cation				10	d. Inside City Limits
	sho	'n	,									1 ☐ Yes 21 No
	Ba-f	ect	Maryland Howa	rd		Columb						
	or 2	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of V		ry?
	n 72 hours after death with the Maryland "natural", or Items 23a or 28a-f show saftal Examinatinus! be indiffed at	Funeral	5384 Harvest				210			U.S		
	e me	Ine	11. Marital Status	Armed F	cedent Ever in U forces?	J.S. 13.	Was Decedent of H f Yes, specify Cuba	ispanic Origin? ( an, Mexican, Pue	Specify Yes or No rto Rican, etc.)	- 14. Rac Blac	e - America ck, White, et	
õ	or Ite	F	1 ☐ Never Married 2 ☑ Married	It Yes. (	ive 2 No	^	1 ☐ Yes 2 ☑ No	Specify:		Specify		
2-0036	within 72 hours ene. than "naturat", ity Wey Gall Ext	d by	3 Widowed 4 Divorced	Year or	Dates: 195	6				opec")	W	hite
ភ	72 h	ete	15. Deceden (Specify only highe	t's Education st grade completed	0	(Give	tent's Usual Occup- kind of work done	during most of w	orking	16b. Kind of Bu	usiness/Indu	ustry
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7	filed w Hygier other th	Completed		4		Regis	stered Nu			Medi		
and	m - 0 2	Be	17. Father's Name (First, Middle,	•				18. Mother's Na	ame (First, Middle,	Maiden Sumam	18)	
<u>a</u>		2	Theodore C. Ka	ese		_		Clara	a E. Resh	1		
a L	2 sho and Is ma		19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailir	ng Address (Street	and Number or P	Rural Route Numbe	er, City or Town,	State, Zip (	Code)
Σ	2 £ 2 ±		Emory F. West	(Husban	d)	5384	Harvest !	Moon Lar	ne Columb	ia, Mar	yland	21044
more,	of Hea of Hea f Item		20a. Method of Disposition			Place of Dispo	sition (Name of natory or other place	ca)	Date	20c. Location -	City or Tow	vn, State
Ē	Pages nent of I int: If It		1X Burial 2 ☐ Cremation `4 ☐ Donation 5 ☐ Other (S		n State		Cemetery	. 1	2-2005	Acciden	+ Mo	rul and
galt	- 문란증		21. Signature of Funeral Service		. 1					Acciden	t, Mai	Гутани
ă	permi Depa Impo any is		1.1.1.11	The state of the s	fant -	Wi	Name and Address tzke Fun 55 Twin	eral Hon	nes, Inc.	mhia M	0 20 77 1 01	-4 0104E
	-	7	23a. Part1. Enter the disease, or	complications that	caused the dear							Approximate
			shock, or heart failure. List Immediate Cause (Final	only one cause on	each line.		1	10				Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a	vacia	ic a	may	now	as		N	mutes
	Examiner		,	Due to	o (or as a consec	quence of):	Card	MA	nath	4	Q	overal
		بد	Sequentially list conditions, if any, leading to immediate	b. Due to	o (or each consec	TVE	Caro	((0)00	011911	7		years
7	be sit	iner	rf any, leading to immediate cause. Enter Undertying Cause (Disease or injury	E Due to	o (or see consec	quence or):	t' lof	the di	elamo	1. 11-	6 -	weap.
	ecute and tran	Examin	that initiated events resulting in death) Last	c. W/1/45	11 vapi	white	for let	Maga	EVIVEING	W 2/00	2	accept the second
ွှဲ	cate be executed physician and the burial-transit	Ê		Due (c	o (or as a consileo	(dericator):		allia	( Daril	(afton		Jeors
2/PU	hysic the b	dical		d								
٥		Mec	IF FEMALE:	7				-				
X Q	death certiff e attending id for use as	clan/Me	23b. Was decedent pregnant		utcome of pregnation in the pregnature of pregnature of the pregna		Ectopic pregnancy	,			e of delivery	<b>'</b>
	ed fo	sici	in the past 12 months? 1 ☐ Yes 2 2 No	4☐Preg 9☐Unk	nant at time of o	death 5□	Other (specify)			Mo	ntn L	Day Year
D	w requires that the death certif been signed by the attending should be detached for use as	Physi	9 Unknown	_								
ຕົ ທົ	ss tha	by	Part II. Other significant condition	ons contributing to	death but not res	sulting in the u	nderlying cause give	en in Part I.	23e. Did t	obacco use conti	ribute to the	cause of death?
cord	aquire en si								10	es 2 No	3 Probal	bly 4 □Unknown
ဝင္ပ	law re as be	ompleted							24a. Was	an 24b. V	Nere autops	sy findings available
Ľ	0 5 0	mo							autor	monet?   c	death?	pletion of cause of
VII	ician: Th certificate rector, pag	C	25. Was case referred to medica	1				OF Place of Do	1 ☐ Yes eath (Check only o		☐ Yes 2	:L NO
>	Physician: r this certific ral director,	OB	examiner? 1 ☐ Yes Z No	Hoepital:	Inpatient 2	ER/Outpatien	t 3 DOA Othe	00	1			
O	aing Phys n. After this funeral di	ļ-	27. Manner of Death	28a. Date	of Injury	28b. Time of		THE PROPERTY OF THE PARTY OF TH	Home A Resident	now injury occurr		
0	ding h. Afte	tlor	Natural 5 Pendir 2 Accident investi	9	nth, Day Year)	Injury	Worl	k? Yes 2 □No				
UNISION	deal deal ctor: y the	fica	3 Suicide 6 Could	not be	e of Injury - At h	ome farm str	eet, factory, office		28f. Location (5	Street and Numb	er or Bural	Route Number
<u> </u>	or A after Dire	Certification:	4 ☐ Homicide determ	buil	ding, etc. (Specia	fy)	out, ractory, emico		City or Tov	vn, State)		
-	purs ours eral filled	ŏ	29a. Certifier Certifyir	ng Physician: To th	a hast of my ba	nwladae doct	nonumed at the ti-	ne data and nin-	a and due to the	cauca/a) and m-	nner ac at-	lad
	Fun Fun	edical	(Check only 2 Medical one)	exeminer: On the	basis of examina	ation and/or in	estigation, in my o	pinion, death occ	urred at the time,	date and place, a	and due to t	he cause(s)
	To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Mec	29b. Signatura and title of certifie		O /		29c. License	e number		29d. Qate şigned	(Month. D	av. Year)
	F 3 F 8		Markon	A 1)	()0.1	111	Da	CRI		chilas		
				110	· CUI	101	) 0000	001		21110	2	
	10		30. Name and address of person	11.100	use of death (Iter	m 23a) (Type,	Print)	Detri	ro Ar	16011	(10)	umhia
	10		3	32.	egistrar's Signa	ature 01	unc	1,0	CKALL D	7	, A1	
	Sta Registr		31. Date filed (Month, Pay, Year)	2005	lieve.	& A	reck				' /	Abort CIN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Wheeler 6. APRIL 2005 1) ONALD /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SILVER SPRIN If Under 1 Year If Under 24 Hrs. Holy CROSS Hospital MONTJONERY 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 215-28-3328 1**⊠**M 2□F Hours 74 Yrs Director JAN 14, Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if itam 27 is marked other than "natural", or tiams 23a or 28a-f show amy njury or other traumatic event, it a Marile Examile of maille of anone. 1 Yes 2 □ No Be Completed by Funeral Director MARYLAND 10e. Street and Number 10g. Citizen of What Country? USA unk 12. Was Decedent Ever in U.S. Armed Forces? unk Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🛛 No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk Elementary/Secondary (0-12) College (1-4or 5+) unk unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) unk unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Holy Cross Hospital 1500 Forest Glen Road Silver Spring, MD 20910 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State ' 4 ☐ Donation 5 🖾 Other (Specify) in state State Anatomy Board 655 W. Baltimore Street 21. Signature of Funeral Service Licensee Ronal H S Wader Aregtor Anatomy board 655 W. B

Baltimore, MD 21201

Sa. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Supsis **Physician** DAYS /Medical Due to (or as a consequence of) Examiner INCUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). or Attanding Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? TRACT 1 Yes 2 No 3 Probably 4 Unknown Dehydration 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy rmed? 22 No this certificate 1 Yes 1 ☐ Yes 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA hours after death.

Inarai Director: After this y filled in by the funeral di 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To tha Funarai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) 732332

DHMH 17 Rev 1/2001

State Registrar 9801

GA. AVE. Silver Spring MO

and address of person who completed cause of death (Item 23a) (Type, Print) EUPTA MO

2. Registrar's Signature

K.

SUL ESh

31. Date filed (Month, Day, Year) MAY 1 2 2005

the Maryland

Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed

Box 68760

P.O.

Division of Vital Records,

To the Hospitel or Attending Physicien:

death.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend items 5,911,12,16b,17-19b per inf. 2855 5-2-06 vt

State of Maryland Department of Health and Mental Hygiene

1- For Unpend Item 23a&27 per me G843 5-13-05 tas
Registrar

Registrar

Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** APRIL 2005 Arthur Ward 24, РМ 1919 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 5512 43rd PLACE HYATTSVILLE PRINCE GEORGES | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Young) | Hours | Min. | 0 ct 14, Young) 5. Social Security Number Unit Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1∭ M 2□ F 091-20-0517 78 Director Yrs. NY. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location item 27 is marked other then "neturel", or items 23e or 28a-f show other treumatic event, it's Madical Examiner must be notified at 10d. Inside City Limits MD Prince George's Director Hyattsville 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5512 43rd Place 20781 Funeral USA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 ☐ Yes 2 X No þ white Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk unk 2 should be filed within and Mental Hygiene. Elementary/Secondary (0-12) Telephone industry College (1-4or 5+) unk unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be George J. Ward Anna E. Dundon 19a. Informant's procheets Jr. 19b. Ma 1020 dr Adelphi Nikoli or Hyatetesvill Cry or Modr. 5/20782 de) Pages 1 and 2 s nent of Health an ant: If item 27 Is 1 111 Penn Street Baltimore, MD 21201 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Pages Department of I Important: If it any injury or o cemetery, crematory or other place) 1 □ Burial 2 □ Cremation 3 □ Removal from State `4□Donation 5 XOther (Specify) in state 21. Si nature r Euneral S rvice Licensee Ronal d'S. Wade, Director State Anatomy Board 655 W. Baltimore Street 23a. Parts. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Prosician Atherosclerotic Cardiovascular Disease /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit physician and Due to (or as a consequence of): Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the a Š Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 autopsy performed? 1 Yes 2 🗆 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) SCENE 1X Yes 2 □ No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 1 ANatural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Certification: Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) APRIL 26, 2005 OCME 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LING 111 Penn Street, Baltimore, Maryland 21201 CI miD 31. Date filed (Month, Day, Year) MAY 1 2 2005 2. Registrar's Signature State Registrar

05-03039 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Harry A. Attick Sr. State of Maryland / Department of Health and Mental Hygiene RJD 1 - For State Registrer Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) May 02, **Physician** 2005 0811A. ATTICK ALLEN /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 29770 Oak Rd. St. Mary's Mechanicsville Birthplace (State or Foreign Country) If Under 1 Year | If Under 2 Months Days Hours 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** 1X M 2 ☐ F Yrs. 84 **Director** 579-12-7174 28,1920 MARYLAND Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location show 10a, State r than "neturel", or items 23a or 28e-f showing Madical Examinational De notilited at 1 ☐ Yes 2 ☐ No Director MECHANICSVILLE MARY'S MARYLAND ST. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20659 Funeral 29770 OAK ROAD 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel', or Iten any injury or other treumatic event, the Mudical Explainment once. 1 Never Married 2 Married 1 ☐Yes 2 ☐ No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Be Completed by Year or Dates: WWII WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) DEPT. OF AGRICULT Elementary/Secondary (0-12) College (1-4or 5+) U.S. GOVERNMENT RESEARCH TECHNICIAN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) CHARLES M. ATTICK ္ရ LILLIAN L. BURSEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TRACI ANN NORRIS-BRANDTER ER F. BUY 9.7,

20b. Place of Disposition (Name of cemetery, crematory or other place)

BYANS SUBLEMENT Date 20c. Location - City or Town, State Baltimore, 20a. Method of Disposition 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 5-6-05 `4 Donation 5 Other (Specify) FT. LINCOLN CEM. BRENTWOOD, MARYLAND 21. Signature of Funeral Service Licensee M00479 22. Name and Address of Facility RAYMOND FUNERAL SERVICE, 23a. Part 1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one casts on each line. Do Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Paysician 00 /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐ Yes 2 ☐ No P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ ances 1 Tyes ZX No 3 Probably 4 Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

funeral dir Certification: after death.

Completed 25. Was case referred to medical examiner? Be ပ 27 Manner of Death

Medical

Hospitel or Attending Physicien: 24 hours a within 24 To the F To the 18

29a. Certifier 29b Signe we

Day. Year) 2005

↑ Yes 2 No

1 Natural

2 Accident Suicide 4 🔲 Homicide 5 Pending investigation 6 Could not be determined

Hospital:

28a. Date of Injury (Month, Day Year)

1 🗌 Inpatient

2 ER/Outpatient 3 DOA 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Home

28c. Injury at Work? 1 Yes

Other:

29c. License number

OCME

5 Residence 6 Other (Specify) 4 🗌 Nursing Home

26. Place of Death (Check only one)

Yes

2 □ No

28d. Describe how injury occurred Location (Street and Number City or Town, Spate) or Rural Route Number 2065 70

Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 XMedicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

May 03, 2005

2 🗆 No

(scene)

Yes

dress of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

111 Penn Street Baltimore, Maryland 21201

Physici	an_	Decedent's Name (First, Middle, Last)	FH PGC 4-29-05cr	Certificate of Death	2. Date of Death Month April 26	3. Time	of Death
/Medic Examir	cal	Charles Alexander  4a. Facility Name (If not institution, give a 2141 Vittoria Cou	street and number)	4b. City, Town, or Location of Dea	ath	4:55 4c. County of Death Prince Georges	A. M
Funeral Director		5. Social Security Number 6. Set 579-44-5953 1X	7. Age (In yrs. last birth	rs. Months Days Hours Mir	s. 8. Date of Birth		e or Foreig
28a-f ehow	ector	10a. State 10b. County Prince Ge  10e. Street and Number	orges Bowie				City Limit es 2 □ N
na 23a or must be r	erai Dir	2141 Vittoria Cour		10f. Zip Code 20721	Un	citizen of What Country? ited States	
ral', or item Examinar	d by Fun	faryland Prince Ge  10e. Street and Number  2141 Vittoria Cour  11. Marital Status  1 Never Married 2 XMarried 3 Widowed 4 Divorced	12. Was Decedent Ever, in U.S. Armed Forces? 5 / 20 / 53 1½ Yes 2 □ No If Yes, Give 5 / 12 / 55 Year or Dates:	13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue) 1 ☐ Yes 2 No Specify:	rto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify:Black	
Department of Health and Medial Hygiene. Important: If item 27 is marked other than "natural; or itema 23a or 28a-f ehow my injury or other traumatic event, the Medical Examinat must be notified at ance.	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 1 2	cation   16a. [	Decedent's Usual Occupation Give kind of work done during most of wo life. DO NOT use retired) Duter Branch Chief	orking 16t	S. Government	
Mental Hyg arked other atic event,	To Be C	17. Father's Name (First, Middle, Last) Charles A. Avent,		Virgini	ame <i>(First, Middle, Mair</i> .a Hartwe11		
eaith and n 27 is m ner traum		19a. Informant's Name/Relationship (Ty Dorothy E. Avent (	Wife) 214	Mailing Address (Street and Number or F	Bowie, Mar	yland 20721	
urtment of Hi ortant: If iter njury or oth		20a. Method of Disposition  1 Burial 2 Cremation 3 F  4 Donation 5 Other (Specify)  21. Signature of Funeral Service Donate	emoval from State 20b. Place of I compteny Mary Lar	Disposition (Name of compatory or other place) and Veterans Cemeter 5/3	Date 200	altenham, Maryl	and
impo any i		Lanny T		Fore Funeral Mome 5538 Marlboro Pike		lle, Md 20747	
ysician Medical		23a. Part1. Enter the disease, or comples shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ne cause on each line.	ot enter the mode of dying, such as cardia		Approxima Interval Be Onset and 2 IVDI	etween d Death
hysician and the burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of Due to (or as a consequence of				
ned by the attending physic detached for use as the b	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day	Year
been signed b should be deta	by	Part II. Other significant conditions cor	stributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of	
ate has page 2	Completed				24a. Was an autopsy performed		
n. After this certificat funeral director, p	Certification: To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending investigation	ospital: 1 Inpatient 2 ER/Outs 28a. Date of Injury (Month, Day Year) Inj	patient 3 DOA Other: 4 Nursing	eath (Check only one)  Home 5 Residence 28d. Describe how in		
	rtifica	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm building, etc. (Specify)	m, street, factory, office	28f. Location (Stree City or Town, S	t and Number or Rural Route Nu tate)	ımber,
ifter death Director: in by the	S		sician: To the best of my knowledge,	death occurred at the time, date and place	e, and due to the cause curred at the time, date	e(s) and manner as stated. and place, and due to the cause	
iffer death	dical	29a. Certifier 1. Certifying Physical Control (Check only one)	ner: On the basis of examination and and manner stated.	rol investigation, in my opinion, death occ			r(s)
		(Crieck Crity Z   Medical Exami	ier: On the basis of examination and	29c. License number	29d.	Date signed (Month, Day, Year) 4-27-05	

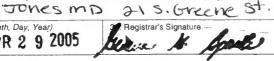
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Day Year **Physician** 1:10.4M Steven April Arquilo 2005 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore University of Maryland Medical Center | Tourist | Transport | Transp 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1**X** M 2□ F Yrs. 1982 Virginia Director 230-29-7178 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ahow s 23a or 28a-f ahor 1 ☐ Yes 2√ No Directo MD Calvert Broomes Island 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 8640A Patuxent Avenue 20615 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. r than "natural", or Itams Black, White, etc. hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: à 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 72 (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Public Education Student 12 other traumatic evant. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) th and Mental h 1 and 2 should be Diana L. Hamlette Steven Robert Arguijo, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20615 19a. Informant's Name/Relationship (Type, Print) Department of Health ar Important: If itam 27 la any injury or other trau 8640A Patuxent Avenue, Broomes Island, Maryland Diana Windsor, Mother Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages ' 1 X Burial 2 ☐ Cremation 3 ☐ Remoyal from State Fort Lincoln Cemetery 05/02/05 Brentwood, Maryland 4 □ Donation / 5 □ Other (Specify) 22. Name and Address of Facility Gasch's Funeral Home, P.A. 21. Signature of Funeral Service Licenses 4739 Baltimore Avenue, Hyattsville, Maryland 23a/Parti Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only/one gause on each line. Onset and Death Immediate Cause (Final disease ir condition resulting in death) Cardiomyopathi Physician /Medical Due to (or as a consequence of): **Examiner** MUSCUlar aystrophy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dus to (or as a consequence of): Examiner physician and The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physiclan/Medical attending IF FEMALE: nse 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year for in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part fi þ Division of Vital Records, 2XNo 3 Probably 4 ☐Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform 1 Yes 2 No 1 Yes 2 No certificate Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 2 ER/Outpatient 3□ DOA this Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: 3 🗌 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 T Homicide 24 hours a Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier ical Medi within 2 the 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number 2 April 27 2005 mo mo

31. Date filed (Month, Day, Year) APR 2 9 2005

Abby

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Registrar

Baltimore mo 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U U 5 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month April 26,2005 Year **Physician** Alford 6:30a. M Rosette /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Holy Cross Hospital Silver Springs Montgomery If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🛱 F 93 256-48-3433 Director May 9,1911 South Carolina Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County item 27 is marked other than "natural", or itema 23a or 28a-f show other traumatic event, the Neulcal Exercities for 1 ☐ Yes 2 XNo Md. Montgomery Silver Springs Direct 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 20910 U.S.A. 1316 Finwick Lane #908 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? filed within 72 hours after Hygiene. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Black þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Dept.Store Seamstress permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If item 27 is marked othe any injury or other traumatic event, once. 17 Father's Name (First Middle Last) 18 Mother's Name (First Middle Maiden Surname) Be Harriette Simpson James Brasman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1316 Finwick Lane#908, Silver Springs, Md. 20910 Brenda Alford (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State
' 4 □ Donation 5 □ Other (Specify) Bethel Cemetery 4-28-05 Alexandria, Va. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lewis Funeral Home St., Alexandria, va. 22314 311 N.Patrick 1914 23a. /ar/1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest the ck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Septicemia **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner yometrium Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed' certificate 2 **Z** No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 1 ☐ Yes 2 X No Certification: To 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) his 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After I or Attending Patter death.

Director: After the 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 3 🗌 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral D 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Safinha k. Sarin MBBS 4. 26.2005 D13548 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10801 LOCKWOOD DRIVE SILVER SPRINGING 20901 AJINDRA SARIN 7005 Year) 32. Phylistrar's Lignatur

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** JAMES EARL BOLT Мау 3:00 **X**M 6 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 3067 Whiteford Road Pylesville Harford If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 230-16-6708 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 15 M 2□ F 82 Yrs. Director 1/13/1923 Virginia Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10h County 10d. Inside City Limits items 23a or 28a-f show other treumatic event, the Medical Examinar must be notified at MD Harford 1 ☐ Yes 2 X No Director Pylesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3067 Whiteford Road 21132 US<u>A</u> Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married ō Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 ☐ Widowed 4 🏋 Divorced "naturel" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 12 should be filed within 7 h and Mental Hygiene. 7 Is marked other then "n College (1-4or 5+) Elementary/Secondary (0-12) Carpenter Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William Enoch Bolt Verdie Belle Carico 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s nent of Health an permit. Pages 1 and 2. Department of Health a Importent: If item 27 is eny injury or other tret once. James E. Bolt/Son 2442 Hunters Trail, Myrtle Beach, South Carolina 29588 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Surial 2 Cremation 3 Removal from State Bel Air Memorial Gardens 5/11/2005 Bel Air, MD ^ 4 ☐Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harkins Funeral Home, Inc., 600 Main St., Delta, FA 17314 23) Fant Enter M disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ISCHELLIC HEART DISEASE Smowth disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): P.O. Box 68760, Physician/Medical JF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 4☐ Pregnant at time of death 5 Other (specify) the 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Chronic Obstructive Lung 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate 2 No 1□ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 🗌 Yes 2 □ ER/Outpatient 3 □ DOA this 28c. Injury at Work? funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 Natural
2 Accident Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation after death Director: / 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours To the Funerel Hospi 29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of 29d. Date signed (Month, Day, Year) 2

State Registrar

31. Date filed (Marth. Day., Year) WAY 1 2 2005

lucent A. Gimelmaro, De 602 South Alexand Rit 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

H0654439

May 6, 2005

201 Palar Mil

State of Maryland / Department of Health and Mental Hygiene U U 5 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Year 25, Thelma W. B. Brown 2005 April 4:20 P. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Hospital Center Cheverly Prince George's Age (In yrs. last birthday) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 1/6/26 Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 € F Director 577-34-9894 Dillon,S.C. Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits "naturel", or Itams 23a or 28a-f show 1 Yes 2 No Director Md. P.G. Capitol Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4306 R Street 20743 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. ATTICAN— Specify: American Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or Itan wy Injury or other traumatic event, Ite Mulcal Examina one. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No 3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed, (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Supervisor/Food Service D.C. School System 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Furman William Wright, Sr. Ethel Knight 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ursaline P. Bryant/Daughter 3717 S. LaBrea Ave. # 429, Los Angeles, Calif. 90016 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State Chesapeake Crematory, Inc. 5/2/05 Beltsville, Md. <sup>¹</sup> 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
H. S. Washington & Sons Co., Inc.
4925 Burroughs Ave., N.E., Wash., D.C. 20019 21. Signature of Funeral Service Licensee Sau W. 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician Acute Renal Failure Days /Medical Examiner Vascular Demontia Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Months Due to (or as a consequence of) Examiner Hospitel or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit Atherosclerotic Vascular Disease Years Due to (or as a consequence of): Box 68760. Physician/Medical Essential Hypertension Years IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav 4☐Pregnant at time of death 5 Other (specify) P.O. signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ Asthma 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗆 No Division of Vital 1 Yes 1 TYes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 🗌 Pending after death. Diractor: A 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 24 hours a Funerel ( 29a, Certifier 1 🙀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D31069 April 26,2005 30. Name and address i person who completed cause of death (Item 23a) Type, Print) George Bone, M.D. 1100 Mercantile Lane, Suite 135, Largo, Maryland 20774 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

APR 2 9 2005

			1 - For State Registrar	State of Maryla	-	artment of			giene	0.05	16133
			1. Decedent's Name (First, Middle, Las	st)				2. Date of Dea	ith		3. Time of Death
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Maryland	should and Men marke umatic		19a. Informant's Name/Relationship (7	Туре, Print) Legal	19b. Maili	ng Address (Stre	eet and Number or R	ural Route Number	r, City or Tox	vn, State, Zip	Code)
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 ie marked other then "natural", or iteme 23s or 28s-1 show any injury or other traumatic event, the Medical Exercities must be notified at any injury or other traumatic event, the Medical Exercities must be notified at any injury or other traumatic event, the Medical Exercities must be notified at any injury or other traumatic event.		21. Signature of Fureral Service Licen				dress of Facility Ga				
Ba	permit. Departn Imports any inju		1 dant	Man			timore Ave				
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			shock or heart failure. List only Immediate/Cause (Final	one cause on each line.			^		631,		Interval Between Onset and Death
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	and P-trar	xan	that initiated events resulting in death) Last	cDue to (or as a cons	equence of):						
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87	physi s the l	Physician/Medical		d							
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Вох	ath c	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of preg 1☐Live birth 2☐Fe	etal déath 3 □	Ectopic pregna				Date of delive Month	ry Day Year
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Division	or Atteno	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - Al		eet, factory, offic	<b>&gt;</b> 8	28f. Location (St		mber or Rura	Route Number,
Ö	al or A s after f Direction by	ert	4   Nomicide	building, etc. (Spe	city)			City or Town	i, State)		
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	To the Hospital or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the	edicai	(Check only 2 Medical Exam	iner: On the basis of exami and manner stated.	nation and/or inv	estigation, in m	y opinion, death occu	rred at the time, da	ate and place	e, and due to	the cause(s)
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n	[0]		30. Name and address of person who o	completed source of death (to	om 22a) (T	Deint)	2555	0			,2003
K	3		SURVA MUN	DRA MD	802	1 RM	Chie i	IWY P	ASA-D	ENS	%,2005 MD.
	Sta Registr	4	31. Date filed (Month, Day, Year) APR 2 9 2005	82. Registrar's Sig	natura Cons						

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2. Date of Death 1 Decedent's Name (First Middle Last) Month Physician BECK MARCUS April 25, 2005 11:15 PM /Medical 4b. City, Town, or Location of Death Silver Spring 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Montgomery Holy Cross Hospital 5. Social Security Number 220-08-4741 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Months 19 Days Hours 1 XM 2 □ F 13,1985 Wash. DC. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h. County DC. Washington Yes 2 □ No Director 10f. Zip Code 20011 . Street and Number 10g. Citizen of What Country? 129 Ingraham St. NW Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Student Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Chase Cedric Anthony Beck Donna 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 129 Ingraham St. NW Wash. DC. 20011 Mildred Beck, Grandmother 20b. Place of Disposition (Name of cometery, crematory or other place Lincoln Mem. Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 4/30/05 1 Burial 2 Cremation 3 Removal from State Suitland, MD. \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Bianchi F.S. 814 Upshur St. NW Wash, DC 20011 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a, Part1, Enter the disease. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ENDSTAGE DILATED CARDIOMYOPATHY Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Litter or denying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Exami Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Dav 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Acute Renal Failure 1 Yes No 3 Probably 4 Unknown Obesity 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗆 No 1 Tyes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo Certification; To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

þ Completed Be

3 Suicide

29a. Certifier

ical

4 Homicide

29b. Signature and title of certifie

The law requires that the death certificate be executed or Attending Physician: this filled in by the funeral After Director:

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, if a Medical Examinal results of any page.

**Physician** /Medical

Examiner

burial-transit

the

attending physician

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760, 24 hours a within 2

State Registrar

Vate

6 Could not be

determined

MD. Potel Jayant

29c. License number 052586

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Glen Rd. Silver Spring, Md. 20910 1500 Forest Jayanti 31. Date filed (Month, Day, Year)

APR 2 9 2005



28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

			For Stete Registrar	State of	Maryland / Dep	eartment of Hertificate of L		nd Mental H	ygiene ()	05   6   35			
	Physici	an	Decedent's Name (First, Middle, I		ELL			2. Date of D Month	Day	Year 8. 4// M			
	/Medic	al	4a. Facility Name (If not institution,			4b. City, Town, or	Location of	Death / Day		2005 8.414 M			
	Examin	er	Howard County			Colum		Dealli	How				
	Funeral		Social Security Number 6	. Sex 7	. Age (In yrs. last birthday		If Under 2 Hours	24 Hrs. 8. Date of B		Birthplace (State or Foreign Country)			
	Director		243-40-5530	1□ M 2 <b>X</b> ) F	74 Yrs.	Monaio Bayo	1.00.0		17,1930	North Carolina			
	and and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or I	ocation	ation 10d.						
	Many fied	ğ	Maryland		Balti	nore				1X∑Yes 2 ☐ No			
	h the	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Country?			
	23a c		623 Allendale	Street		221	29		United	States			
Maryland 21215-0036	172 hours after death with the Maryland "netural", or Items 23a or 28a-f show calcel Exaciting in the benefited at	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Ford	es? No	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 No	n, Mexican,	jin? (Specify Yes or N Puerto Rican, etc.)	No- 14. Race - American Indian, Black, White, etc.  Specify: Black				
5-0	72 hc	etec	15. Decedent's (Specify only highest	Education grade completed)	(Giv	edent's Usual Occupa e kind of work done o	urina most	of working	16b. Kind of E	Business/Industry			
121	d within 72 ho piene. r than "netui the Modical	Completed	Elementary/Secondary (0-12)	College (1-	4or 5+)	DO NOT use retired,  d Care Pr		r	Do	mestic			
d 2	를 수 를 는		17. Father's Name (First, Middle, La	st)	GIII	id Care II		's Name (First, Middi					
an	₫ ₩ <b>0</b> •	To Be	John Sam Mo	ore			Ros	a Bell S	Spruill				
ary	s 1 and 2 should f Health and Men item 27 is marke other traumatic		19a. Informant's Name/Relationship	(Type, Print)	19b. Mai	ling Address (Street a	ind Number	r or Rural Route Num	ber, City or Town	n, State, Zip Code)			
	1 and 2 Health tem 27 i			Husband)			Stre			yland 22129			
Baltimore,	Pages 1 nent of H int: If iter iry or oth		20a. Method of Disposition  1   Burial 2 □ Cremation 3  4 □ Donation 5 □ Other (Spe		tate	nosition (Name of The matory or other place The Cemeter		Date 2005 pril 30,		- City or Town, State North mston, Carolina			
Balti	permit. Pages 'Department of H Important: If ite any injury or of Once.		21. Signature of Funeral Service Lie	censee		Name and Addres W. Wesley 722 North	s of Facility Cha Capi	vis III Fu tol Street	meral S	ervices,PA,Inc. ashington,D.C.			
			23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that cally one cause on ea	used the death. Do not e	nter the mode of dying	g, such as o	cardiac or respiratory	arrest,	Approximate Interval Between			
	Pnysician		Immediate Cause (Final disease or condition		etas bottec	Breast	Ca	1 cenima	ò	Onset and Death			
	/Medical Examiner		resulting in death)	neterratic Breast Carcining  Due to (or as a consequence of):  End Stay Renal Cailure									
	LAdillilei	er	Sequentially list conditions, if any, leading to immediate	b. Due to (o	r as a consequence of):	may pa	con	<u> </u>					
	nsit		Cause, Enter Underlying Cause (Disease or injury	mine	,								
Ć,	be executed sician and burial-transit	resulting in death) Last  Due to (or as a consequence of):											
8760,	cate be executed physician and the burial-transit	d											
9	ing ph	w r	IF FEMALE:										
Box.	death certifi le attending l ad for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No	1 Live bir	nt at time of death 5	□Ectopic pregnancy □ Other (specify)			23d. Date of delivery Month Da				
P.0	that the de ed by the detached	Phys	9 Unknown					age Die	lanhana was asa	Salara de de carres de de cale O			
	w requires th been signed should be d	eted by	Part II. Other significant condition	s contributing to dea	ith but not resulting in the	underlying cause give	in in Paπ I.			ntribute to the cause of death?  3 Probably 4 Onknown			
Vital Records,	he lar e has age 2	duo						24a. Wa aut per 1 \( \text{Yes}	opsy formed?	Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No			
ta		Be C	25. Was case referred to medical				26. Place	of Death (Check only		10,103 20110			
of V	ysic lis ce direc	2	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	patient 2 ER/Outpati	ent 3 DOA Othe	er: 4 □ Nur	sing Home 5 Res	sidence 6 □Ot	her (Specify)			
ion o	ing After une	ation:	27. Manner of Death  Natural 5 Pending 2 Accident investigat		Injury 28b. Time , Day Year) Injury	Work	at ? /es 2 □ N		how injury occu	rred			
Division	of or Attend after death Director: A	ertification:	3 Suicide 6 Could no 4 Homicide determin	ad 286. Place o	of Injury - At home, farm, s g, etc. <i>(Specify)</i>	treet, factory, office		(Street and Num own, State)	ber or Rural Route Number,				
	To the Hospital or within 24 hours after To the Funeral Direction completely filled in h	edical C	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the base aminer: On the base and manne	pest of my knowledge, deasis of examination and/or er stated.	ath occurred at the time nvestigation, in my op	e, date and sinion, deat	d place, and due to the h occurred at the time	e cause(s) and m e, date and place	nanner as stated. , and due to the cause(s)			
20	To the within 2 To the complet	Me	29b. Signature and title of certifier	`		29c. License	number		29d. Date sign	ed (Month, Day, Year)			
			<b>&gt;</b> 40	leen		<i>y</i> 3	064	-1	April	25 2005			
_			30. Name and address of person with Rameth Sabe	no completed cause	of death (Item 23a) (Type 3 400 Evalu	on Aven	e B	Saltimore	Maryl	ard 21213			
	Sta Registr		31. Date filed (Month, Day, Year) APR 2 9 200	5 Sec. Re	gistrar's Signature	le				and due to the cause(s)  ed (Month, Day, Year)  25 200 5  and 21215			

			For State Registrar		Maryland		artmen rtificate			and M		Reg. No	005	161	36
	Physici		1. Decedent's Name (First, Middle Juanita	Maxine	I	Barr					Apyll	Day 26	2005	3. Time of 8:3	of Death
	/Medic Examin		4a. Facility Name (If not institution,		•			Town, or	Location of			4	ounty of Death	<del>-</del>	
			Renaissance Ga	rden at Ri	derwood	Vill:	age		Silve	er Sp	ring		Montgo	mery	
	Funeral Director		5. Social Security Number 464-01-7116	6. Sex 7. 1 ☐ M 2 🔀 F	Age (In yrs. last	Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bird (Month, Dat July 19	h y, Year) 9, 19	9. Birthp Cour 11 Ok1	olace (State o ntry) ahoma	or Foreign
	and and		Usual Residence of Decedent  10a. State 10b. County		10c. City, T	own or Lo	cation						1	0d. Inside C	ity Limits
	Mary f sho	tor	Maryland M	ontgomery	9	Silve	r Spr	ina							24□ No
	n the	irec	10e. Street and Number				10f. Zip					10g. Citize	on of What Cour	itry?	
	23a c	al D	3113 Helsel Dr	ive			2	20906	5				USA		
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural; or Items 23a or 28a-f show any injury oc other treumatic event, If a Modical Exertified: as one.	Completed by Funeral	11. Marital Status  1 Never Married 2 Marri  3 Widowed 4 Divorced	12. Was Decede Armed Force ed 1 \( \subseteq Yes \) 2 If Yes, Give Year or Date	as? █No	1	Was Deced If Yes, spec 1 🗆 Yes 2			gin? (Spe i, Puerto	ecify Yes or No Rican, etc.)	1	Race Americ Black, White, pecify: Whi	etc.	
2-0	72 ho	eted	15. Decedent (Specify only highes		1	6a. Deced	dent's Usua kind of wor	l Occupa	ation during mosi	t of worki	na	16b. Kind	of Business/Inc	dustry	
7	vithin ne. han *	mpl	Elementary/Secondary (0-12)	College (1-4	or 5+)	life.	DO NOT us	e retired	)						
22	Hygie ther t int, III	CO	17. Father's Name (First, Middle, I	ast) 4		HOM	emake	r	18. Mothe	r's Name	(First, Middle.	Maiden S	Own Hom	ıe	
Maryland	lould be I Mental I narked o	To Be	William Burde	tt Tubbs					Ве	ertha	a Sarah	Ayle	sworth		
Mai	d 2 sh th and 17 Is n treun		19a. Informant's Name/Relationsh Elizabeth Marsl										Town, State, Zip ID 20904		
Baltimore,	tiges 1 and 2. In of Health are: If item 27 Is		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation	3 □Removal from Sta	20b. Place	e of Dispo	osition (Naminatory or of	ne of ther place	9)	Apri	ate 27,		ation - City or To		
豊	artmer ortent njury	-	* 4 □ Donation 5 □ Other (Sp. 21. Signature of Funeral Service L		Mecror			_					ndria,	Virgir	nia
Ba	Depz Impo any	j = a, , s=1ver spring, ne													
	Physician /Medical		23a. Part1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	a. Advanc	ed Alzh	eime				cardiac c	r respiratory ar	rest,		Approximat Interval Bet Onset and I	ween
	Examiner		Due to (or as a consequence of):  Failure to Thrive b. Failure to Thrive												
١.	sit ad	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury												
ó	ate be executed hysician and the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or	as a consequen	ce of):					_				-
68760,	ficate be physicial sthe bu	edical		d.											
P.O. Box	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the buriat-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🌋 No 9 ☐ Unknown		n 2 ☐ Fetal de t at time of death	ath 3	Ectopic pre Other (spe					23	d. Date of delive Month		Year
	quires that the de n signed by the a lid be detached f	by	Part II. Other significent conditio	ns contributing to deat	h but not resultin	ng in the ur	nderlying ca	ause give	en in Part I.				contribute to th		
I Records,	The ate h page	Completed									24a. Was autop perfor 1 \( \text{Yes} \)	sy med?	death?	osy findings and pletion of ca	available ause of
/ita	ician: Th certificate rector, pag	Be (	25. Was case referred to medical examiner?							of Death	(Check only o	ne)			
of	두 두 등	2 2	1 Yes 2 No 27. Manner of Death	Hospital:		/Cutpatien			442 Nu				Other (Specify	')	
CO	ding h. After funer	tion	1 Natural 5 Pending		Day Year)	b. Time of Injury	M	Bc. Injury Work	at ? ∕es 2 □ l		28d. Describe h	ow injury o	occurred		
Division of Vital	il or Attending Physician: after death. Director: After this certification by the funeral director.	Certification:	2 Accident Investig 3 Suicide 6 Could n 4 Homicide determi	ot be 28e. Place of	Injury - At home etc. (Specify)	, farm, str				-	28f. Location (S City or Tow	itreet and I n, State)	Number or Rura.	l Route Num.	ber,
_	Hospital 24 hours Funeral stely filled	edical Ce	29a. Certifier 1 Certifying (Check only one)	g Physicien: To the be exeminer: On the basis and manner	s of examination	dge, death and/or inv	n occurred a	at the tim in my op	e, date and inion, deat	d place, a	and due to the c	ause(s) ar	nd manner as stace, and due to	ated. the cause(s	:)
	To the within 2 To the complet	Med	29b. Signature and title of certifier				29c.	License	number			29d. Date s	signed (Month, I	Day, Year)	
4			> Loveen	Puthun	lang	MD		D:	59524			April	27, 20	005	
(	O		30. Name and address of person v	who completed cause of		a) (Type,	Print)	Road	, Sil	ver	Spring	MD 3	20904		
	Sta Registr		31. Date filed (Month, Day, Year)		istrar's Signature							.1.0 2			

11. Marital Status    12. Was Decedent Ever in U.S. Amed Forces?   1   Yes, specify Cuban, Mexican, Puerto Rican, etc.)   13. Was Decedent of Hispanic Origin? (Specify Yes or Not If Yes, specify Cuban, Mexican, Puerto Rican, etc.)   1   Yes, Specify Cuban, Mexican, Puerto Rican, etc.)	26, 2005 2:29 A		
SCHN HORKINS BAYVIEW MEDICAL CENTER   SALITIMORE   S. Social Security Number   5. Social Security Number   6. Sex   7. Age (In yrs. last birthday)   If Under 1 Year   Months   Days   Hours   Min.	4c. County of Death		
10a. State   10b. County   10c. City, Town or Location   FORT WASHINGTON	9. Birthplace (State or Foreign 8,1961 WASHINGTON, D.C.		
Elementary/Secondary (0-12)  College (1-4or 5+)  ADMINISTRATIVE CLERK  17. Father's Name (First, Middle, Last)  WADE E. BROWN, SR.  19a. Informant's Name/Relationship (Type, Print)  SAUNDRA BROWN—SAVOY / SISTER  20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  1 Burial 2 Cremation 3 Removal from State  1 College (1-4or 5+)  ADMINISTRATIVE CLERK  18. Mother's Name (First, Middle, Last)  WADE E. BROWN, SR.  19b. Mailing Address (Street and Number or Rural Route Number or Rural Rout	10d. Inside City Limit		
Elementary/Secondary (0-12)  College (1-4or 5+)  ADMINISTRATIVE CLERK  17. Father's Name (First, Middle, Last)  WADE E. BROWN, SR.  19a. Informant's Name/Relationship (Type, Print)  SAUNDRA BROWN—SAVOY / SISTER  20a. Method of Disposition  12b. Burial 2 Cremation 3 Removal from State  12 Name and Address of Facility  APRIL 30,2005  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory a shock, or heart failure. List only one cause on each line.	1 ☐ Yes 2 ☐ N 10g. Citizen of What Country?		
Elementary/Secondary (0-12)  College (1-4or 5+)  ADMINISTRATIVE CLERK  17. Father's Name (First, Middle, Last)  WADE E. BROWN, SR.  19a. Informant's Name/Relationship (Type, Print)  SAUNDRA BROWN—SAVOY / SISTER  20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  1 Burial 2 Cremation 3 Removal from State  1 College (1-4or 5+)  ADMINISTRATIVE CLERK  18. Mother's Name (First, Middle, Last)  WADE E. BROWN, SR.  19b. Mailing Address (Street and Number or Rural Route Number or Rural Rout	Specify: BLACK		
APRIL 30,2005    APRIL 30,2005	16b. Kind of Business/Industry  FEDERAL GOVERNMENT		
APRIL 30,2005    APRIL 30,2005	· · · · · · · · · · · · · · · · · · ·		
APRIL 30,2005    APRIL 30,2005	VASHINGTON, D.C. 20001		
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory a shock, or heart failure. List only one cause on each line.	20c. Location - City or Town, State  CLINTON, MARYLAND		
snock, or heart failure. List only one cause on each line.	AD, MARYLAND 20640		
Physician /Medical Examiner  Immediate Cause (Final disease or condition resulting in death)  Immediate Cause (Final disease or condition resulting in death)  Immediate Cause (Final disease or condition resulting in death)  STEPHENS—JOHNSON SYNDROME  Due to (or as a consequence of):  TOXIC EPIDERMAL NECROLYSIS  Due to (or as a consequence of):  Co.  Due to (or as a consequence of):	Interval Between Onset and Death 9 DAYS		
FFEMALE: 23b. Was decedent pregnant in the past 12 months?   1   Yes   2   No   No   No   No   No   No   No	23d. Date of delivery Month Day Year		
9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did to the significant conditions contributing to death but not resulting in the underlying cause given in Part I.	obacco use contribute to the cause of death?  'es 2 X No 3 Probably 4 Unknown		
24a. Was			
F			
27. Manner of Death  1	Street and Number or Rural Route Number, m, State)		
29a. Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the convergence on the convergence	cause(s) and manner as stated. date and place, and due to the cause(s)		
RES-000	29d. Date signed (Month, Day, Year)		
30. Name and address of person who pleted cause of death (Item 23a) (Type, Print)  LIPIKA SAMAL, MD 4940 EASTERN AVENUE, BALTIMORE, MARYL  State Registrar  ADD 2 0 2005	4/28/05		

		,		of Maryland / Dep Ce		lealth and M	ental Hygi	•	16138
/	nysicia Medic kamin	al	1. Decedent's Name (First, Middle, Last)  4a. Facility Name (It not institution, give street and not not institution).	V. Car		r Location of Death	2. Date of Death	Day Year 2005  4c. County of Death Prince G	3. Time of Death 10:30p M
	neral ector		5. Social Security Number 6. Sex 1 M 2哲 F Usual Residence of Decedent	7. Age (In yrs. last birthday 91 Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, April 12		lace (State or Foreign
Iryland 21215-0036 should be filed within 72 hours efter death with the Maryland and Mental Hygiene. marked other then "naturel", or flems 23a or 28e-1 show	ritier; sat be notified at	by Funeral Director	MarylandPrince Georges  10e. Street and Number 7612 Temple Hill Rd.  11. Marital Status 10b. County Records 110b. County 110b. County 120b. County 1	2% No			U	g. Citizen of What Cour nited State	es an Indian, etc.
i Hygi	event, If a Madical Exa	Be Completed by	15. Decedent's Education (Specify only highest grade completed Elementary/Secondary (0-12) 12  17. Father's Name (First, Middle, Last)	Dates: 16a. Dec (Giv (1-4or 5+)	edent's Usual Occup e kind of work done DO NOT use retired Dervisor I	ation during most of working	abor	Specify: Blace Sb. Kind of Business/Ind Federal Government	dustry
MG 2 state at the art 27 ls	er treumatic	To	James Jackson  19a. Informant's Name/Relationship (Type, Print)  Jane C. Dickens / Daug		ling Address (Street Texas Ave		l Route Number, (	City or Town, State, Zip D.C. 200	Code) 019
Baltimore, Dermit. Pages 1 a Department of Hea	njury or othe		20a. Method of Disposition  1   Burial 2 □ Cremation 3 □ Removal from 4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee	Lincol	position (Name of ematory or other place of the Memoria	1 4/30/	2005 S	oc. Location - City or To	i.
Dega Bagg	eny ir		23a. Part1. Enter the disease, or complications the shock, or heart failure. Ligt only one cause on	caused the death. Do not er				Homes, P.A.	20747 Approximate Interval Between
B / 600, rate be executed THE / Mex	lical iner	Ical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underfug Cause (Disease or injury that initiated events resulting in death) Last  Due to d.	IABET ES	F 11	-114 -114	) (SA	45.F	Onset and Death
<b>BOX 6</b> ath certific	tached for use as the	Physician/Med	in the past 12 months?	nant at time of death 5	□Ectopic pregnancy			23d. Date of delive Month	ry Day Year
ecords, P. law requires that it is been signed by	peq	by	Part II. Other significant conditions contributing to	death but not resulting in the	underlying cause give	en in Part I.		cco use contribute to th	e cause of death? ably 4 📆 Unknown
VITAI HECC ilcien: The law re certificate has be	36.2	e Completed	05 W.				24a. Was an autopsy performe	prior to con death?	osy findings available inpletion of cause of
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DIVIS itef or Atte its after dei	led in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place built	e of Injury - At home, farm, st ding, etc. <i>(Specify)</i>	treet, factory, office	2	8f. Location (Stree City or Town,	et and Number or Rural State)	Route Number,
DIVISION OF To the Hospitel or Attending Phy within 24 hours after death. To the Funerel Director: After this	completely fill	Medical	29a. Certifier (Check only one)  1 ★ Certifying Physician: To the check only one)  2 ★ Medical Examiner: On the and rha  29b. Signature and title of certifier  30. Name and address of person who completed care	basis of examination and/or in	29c. License	pinion, death occurre	d at the time, date	se(s) and manner as sta and place, and due to . Date signed (Month, L	the cause(s)
Re	Stat egistra		Andre S. Michalak, M.I		Street N	.E. S-208	B Washin	gton, D.C.	20017

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygierie 1 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** April 27,20°5 Marguerite 1:30PKathleen Cooksey /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Morningside House Waldorf Charles f Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ M 2 1 X F Months Days Hours Min. 215-38-3669 Yrs. 98 31.1906 May Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 7 No Be Completed by Funeral Director MD Charles Waldorf 10e. Street and Number Of, Zip Code 10g. Citizen of What Country? 70 Village Street 20601 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 3X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas W. Bowling Daisy Marie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carl Hornbeak/Nephew 6701 Eilerson St. Clinton,MD 20735 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State United Methodist Cem. 4/30/05 La Plata, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee -ECHOLS FUNERAL HOME, P.A. 206 4 6 proximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one puise on each line. Immediate Cause (Final DVANCE disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medicai IF FEMALE: If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one)

Priysician /Medical Examiner or Attanding Physician: The law requires that the death certificate be executed burial-transit Box 68760. the P.O. Division of Vital Records.

**Funeral** 

Director

28a-f show

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death with the Maryland

filed within 72 hours after

Baltimore, Maryland 21215-0036

director, page 2 should Certification: To After after death

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Be Completed

27. Manner of Death

Medical

State

Registrar

4 Homicide 29a. Certifier (Check only one) 29b. Signature and title of certifier

examiner'

1 XNatural

2 Accident

3 🗌 Suicide

1 ☐ Yes 2X No

5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)

Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA 28b. Time of Injury

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Other: 4 Nursing Home 5 Residence 6 X thASSISTED

28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

Living

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TIGGIN

filed (Month, Day, Year) APR 2 9 2005

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** 5:00 ам Downey April 27, 2005 /Medical 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Silver Spring Mariner Health Care-Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug. 16, 1912 5 Social Security Number 6. Sax 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1 M 2 X F 252-01-9835 Yrs. Aug. Georgia Director 92 Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylai Department of Heatth and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or items 23e or 28e-1 show early injury or other treumetic event, Ite Madical Examinar must be inclified at once. 1 ☐ Yes 2 ☑ No Director Maryland Montgomery Silver Spring 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20901 IISA 9505 Curran Road by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ᠫ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 AWidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Annie Luther Richard Henson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9505 Curran Road, Silver Spring, Maryland 20901 Linda D. Newman/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State April 27, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crematory 2005 Alexandria, Virginia \* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses Francis J. Collins Funeral Home Inc KenSkile 500 University Blvd, W, Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician 1 Week Pneumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy for in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) P.O. the detached signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ Progressive Dementia 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 2 should Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? has The page certificate 2 No 1 Yes 1 Yes 2X No Hospitel or Attending Physicien: funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: ပ 1 ☐ Yes 2 🛣 No 1 Inpatient 2 ER/Outpatient 3 DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Injury 1 XNatural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide hours after within 24 hours aft

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completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of sertifier 29d. Date signed (Month, Day, Year) 29c. License number D09834 August 27, 2005 KLA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Barry N. Rosenbaum, M.D. 3720 Farragut Avenue, Kensington, MD 20895-2110 31. Date filed (Month, Day, Year)
APR 2 8 2005 22. Registrar's Signature State Registrar

Physicia: /Medica		Decedent's Name (First, Middle, Last	st)				2. Date of D	eath Day	3. Time of D		
Alvieotica		John Issac Ennis					APRIL	25,	2005 2:51p		
Examine		4a. Facility Name ( <i>If not institution, give</i> 11 EAST SOUTH STRE	e street and number) ET APT 2		4b. City, Tow FREDER	n, or Location of ICK	Death	Fi	REDERICK		
Funeral Director		213-46-9863	Khu an e	yrs. last birthday, 57 Yrs.	Months Da		Min. 8. Date of B Month, L Aug. 2	irth Day, Year) 0 , 19	9. Birthplace (State or I Country) Maryland		
*	ŀ	Usual Residence of Decedent  10a. State 10b. County	10c	. City, Town or L	ocation				10d. Inside City		
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28e Postiff	Directo	Maryland   Fredericl	C Fre	ederick	10f, Zip Coo	ie		10a, Cit	izen of What Country?		
Sa or		ll East South Stre	20#		21701			USA			
ms 2	Funerai	11. Marital Status	12. Was Decedent Ever	in U.S. 13.		of Hispanic Origi	in? (Specify Yes or N Puerto Rican, etc.)		14. Race - American Indian,		
A SE	ᆵ	1 ☐ Never Married 2X Married	Armed Forces? 1 X Yes 2 ☐ No				Puerto Rican, etc.)		Black, White, etc.		
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Ment		John Edward Ennis				Glenna	a Mae Deha	rt			
and samma		19a. Informant's Name/Relationship (	Type, Print)	19b. Mail	ing Address (Str	eet and Number	or Rural Route Num	ber, City o	r Town, State, Zip Code)		
n 27		Helen Ennis, wife					t, Frederi				
r oth		20a. Method of Disposition  1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other place)						20c. Location - City or Town, State			
nent ent: I ury o		`4 □ Donation 5 □ Other (Specify		mithsbu:	rg Crema	atory 5/	3/2005	Smit	hsburg, Marylaı		
Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "natural", or items 23a or 28e-1 ehov any injury or other traumetic event, the Medical Examinat must be notified at 9RGs.		21. Signature of Funeral Service Licer	~	400999 1	2. Name and Ad	dress of Facility	Keeney ar Street, F	id Bas	sford Funeral H		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND#28a-freeME5/5/05, BW, MCC; Maryland / Department of Health and Mental Hygiene 1- State RegistraMEND#26perMD4/28/05, BW, MCC; Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No. Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 24 2005 **Physician EDWARD ESCHENBAUM** APRIL 6:05 A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner SAINT MARY"S NAS PATUXENT RIVER PATUXENT RIVER If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) **Funeral** Days Hours 1**X**□M 2□F Months Yrs. Director APR. 20,1984 562-85-7581 CALIFORNIA Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Indepartment of Health and Mental Hygiene. Indepartment of Health and Mental Hygiene. Indepartment if item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or either traumatic event, it e Modical Examinational be notified at once. 1 XYes 2 No Director CA. PLUMAS OUINCY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 768 OLD MEADOW VALLEY RD. 95971 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ▼Yes 2 No If Yes, Give 2002— Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Never Married 2☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced Year or Dates: WHITE 2005 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 U.S. MARINE DEFENSE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ROBERT Ε. **ESCHENBAUM** WOOTEN MARTI.YN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROBERT E. ESCHENBAUM/FATHER 768 OLD MEADOW VALLEY RD., QUINCY, CA. 95971 20b. Place of Disposition (Name of cometery, cremeter STRTICTCEM.

MEADOW VALLEY CHURCH 4-30-2005 20a. Method of Disposition 20c. Location - City or Town, State 1 

Burial 2 □ Cremation 3 □ Removal from State Meadow Valley, CA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Censee 22. Name and Address of Facility CHAMBERS FUNERAL HOME & CREMATORIUM, P MALCI M00091 5801 CLEVELAND AVE., RIVERDALE, MD. 20737 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) GUN SHOT WOUND OF THE HEAD Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): burial-transit Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed Due to (or as a consequence of): attending physician for use as the burial Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Year Month in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) Yes 2 □ No detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ▼ Yes 2 □ No 24a. Was an autopsy performed: 2 No or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 4 Nursing Home 5 Residence 6 Noval Base Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient ♣☐ BOA Other: 1 XYes 2 ☐ No 2 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Apr 24 2005 6:05AM Yes 2□No GUN SHOT 2 Accident 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  $\begin{array}{ccc} POST & 2 \end{array}$ 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined NAS PATUXENT RIVER MD To the Hospital within 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2005 atl 02002280A (IN) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) nATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600 SEAN SWIATKOWSKI LCDR MC USNR 31. Date filed (Month, Day, Year) legistrar's Signature State 28 Registrar

		1	For State Registrar	State o	f Maryla		artment <i>tificate</i>			ınd M	ental Hyg	ene () (	)5	16144	
	Dhuaiaic		1. Decedent's Name (First, Middle,								2. Date of Death	n Day	Year	3. Time of Death	
	Physicia /Medic	al -		Marguer		tters					April	28,20	25	21,45 M	
	Examin	er	4a. Facility Name (If not institution, g		mber)		,		Location o			4c. Count	4c. County of Death		
			2010 Hopewell  5. Social Security Number 6	Road	7 Age (In yes	. last birthday)	If Under		Depos		8. Date of Birth	th (Year) 9. Birthplace (State or Foreign Country)			
	Funeral Director		219-18-4191	1 □ M 2 🖾 F	80	Yrs.		Days	Hours	Min.	(Month, Dav.	1925		ntry) iryland	
			Usual Residence of Decedent		. ,										
	irylan show		10a. State 10b. County		10c. C	city, Town or Lo								10d. Inside City Limits 1 ☐ Yes 2 ☑ No	
	Ba-1:	Director	Maryland Cec	:11					Depos	sit		og. Citizen of	Milhad Cou		
	be filed within 72 hours after death with the Maryland Ital Hygiene.  Id Hygiene.  Id other than "netural", or Items 23e or 28e-1 show event, the Medical Exar 4 are must be 1 willied at event, the Medical Exar 4 are must be 1 willied at	吉	10e. Street and Number 2010 Hopewell	Road			10f. Zip		21904			-	J.S.A		
	ns 23	Funeral	11. Marital Status		edent Ever in	U.S. 13.	Was Deced			gin? (Spe	cify Yes or No-			can Indian,	
-	r Item	표	1 Never Married 2 Marrie	Armed Fo	orces? 2⊠No					, Puèrto	cify Yes or No- Rican, etc.)		ack, White	, etc.	
21215-0036	ral', o	þ	3 ☐ Widowed 4 🖾 Divorced	If Yes, Gi Year or D	ve )ates:		1 ☐ Yes 2	No LES	Ѕреспу:			Speci	ty:	White	
2	72 hc	Completed	15. Decedent's (Specify only highest	Education grade completed)		(Give	dent's Usua kind of wor	k done d	during most	of worki	ng	16b. Kind of E	3usiness/Ir	ndustry	
21	vithin ne. han "	du	Elementary/Secondary (0-12)	College (	1-4or 5+)	life.	<i>DO NOT u</i> s Homen					Perso	nal	Residence	
	filed within 72 h I Hygiene. other than "netuent, in Medica		Twelve Years  17. Father's Name (First, Middle, La	ıst)			Homen	iake.		r's Name	(First, Middle, M			11001401100	
ano	d be d antal l ced o	To Be		nknown						C	hristina	Marte	<b>=1</b>		
Maryland	s 1 and 2 should be f f Health and Mental I ftem 27 Is marked of other traumatic eve	-	19a. Informant's Name/Relationship	o (Type, Print)		19b. Maili	ng Address	(Street	and Numbe	r or Rura	I Route Number	City or Town	n, State, Zi	p Code)	
	P 등 다 두		David E. Fetter	cs, Sr.		_				, Po	rt Depos	sit, Ma	aryla	nd 21904	
ore	of He of He roth		20a. Method of Disposition 1	t □Removal from	State 20b.	Place of Dispo cemetery, cre-	osition (Nam matory or ot	ne of ther plac	(8)		Date	20c. Location	- City or T	own, State	
Ĕ	Pages ment of I ent: If its ury or o		'4 □Donation 5 □Other (Spe		P	arkwood	Ceme	tery	7	05/0	2/05	Baltim	ore,	Maryland	
Baltimore,	permit. Pages 1 an Department of Heal Importent: If item 2 any injury or other once.		21. Signature of Funeral Service Li	TOURN	201. G	r. L	errvv	Pat ille	terso	n & vlar	Son Fun	3-0766	ome,	P.A.	
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												
B	Physician		Immediate Cause (Final disease or condition resulting in death)  a. Ut wine Cancer											Onset and Death	
30	/Medical Examiner		resulting in death)		(or as a cons										
	LAGITITICI	<u></u>	Sequentially list conditions, if any, leading to immediate	b	(or as a conse	equence of):			_						
0	nsit	nin	Cause (Disease or injury		(										
7	te be executed ysician and te burial-transit	Examiner	that initiated events resulting in death) Last	equence of):											
,097	eath certificate be executed attending physician and for use as the burial-transit	cal		d											
89	rtifica ng ph	Med	IF FEMALE:												
Box	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as th	Physiclan/Med	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live	itcome of preg birth 2 Fe	etal death 3	□Ectopic pr		,				ate of deliv Ionth	very Day Year	
0	the a	ysic	1 ☐ Yes 2 🔯 No 9 ☐ Unknown	4⊟Preg 9⊟Unki	nant at time of nown	rdeath 5	Other (sp	өспу)							
Д.	that the ed by	H.	Part II. Other significant condition	s contributing to	death but not r	esulting in the u	inderlying c	ause giv	en in Part I		23e. Did tol	acco use co	ntribute to	the cause of death?	
ds,	uires sign lid be	d by	Non ins	din des	endent	1 1,26	et es				1 □ Ye	s 2 No	3 ☐ Pro	ebably 4 Unknown	
Record	w requir s been si s should	lete		, ,							24a. Was a		. Were aut	opsy findings available	
	The la te has	Completed									autops perform		death?	ompletion of cause of	
Vital	itan: rtifice ctor, p	Be C	25. Was case referred to medical examiner?						26. Place	of Death	(Check only on	e)			
of V	Physician: rthis certific ral director,	To	1 ☐ Yes 2 No			☐ ER/Outpatie			4 🗆 140		me 5 Reside		ther (Spec	Joh shome	
n o	ing P	on:	27. Manner of Death  Natural 5 ☐ Pending		of Injury nth, Day Year)	28b. Time of Injury	of 2	8c. Injur Wor	yat rk? Yes 2. □		28d. Describe ho	w injury occi	urred		
isio	Attending r death. ector: After by the fune	icat	2 Accident investigation investigation Accident 6 Could not	ot be	e of Injury - At	home, farm, st			163 2 🗆		28f. Location (Si	reet and Nun	nber or Rui	ral Route Number,	
Division	after after Direct In by	Certification:	4 ☐ Homicide determin	build build	ding, etc. (Spe	cify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	, 011100			City or Town				
	ne Hospital or Attendi 24 hours after death. ne Funerel Director: A bletely filled in by the f	edical C	29a. Certifier 1 Certifying (Check only 2 Medical E	Physician: To the	e best of my k	nowledge, dea	th occurred	at the tir	me, date ar	nd place, ith occurr	and due to the c	ause(s) and nate and place	nanner as	stated. to the cause(s)	
	To the Hospital or Attanding Physician: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2.	Medi	one) 29b. Signature and title of certified		nner stated.				se number			9d. Date sign			
)	,		> 1/0 fark	es, M	17		j	114	531	4		pr: 12	9,20	v5	
	5		30. Name and address of person w	no completed car	use of death (I	tem 23a) (Type	Print) Le	sup	whe	1tos	pice El	kton	MD		
	Sta Regist		31. Date filed (Month, Day, Year) APR 2 9	2005	Registrar's Sig	inature	sel.	,		′1					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] 5 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 26, <sup>Day</sup> 2005 Betty Mae Fagan 0105 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Calvert Memorial Hospital Prince Frederick Calvert If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Days 1 ☐ M 2 🖫 F Months Hours 68 579-46-7263 July 10, 1936 Virginia Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Dunkirk 1 ☐ Yes 21 No Calvert 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 20754 3007 Ashwood Drive USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 X No 1 ☐ Yes 2X No Specify: White 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Printing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Wallace Morris Lester Margaret 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Felicia Saffarinia (daughter) 3221 Patrick Henry Dr. Falls Church, VA 22044 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Apr 29 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Resurrection Cem. \* 4 ☐ Donation 5 ☐ Other (Specify) 2005 Clinton, MD 21. Signature Fur ral Service Licensee 22. Name and Address of Facility Lee Funeral Home Calvert, PA 20736 J. Goff 8125 Southern Maryland Blvd. Owings, MD Gary 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 04 structure evere Due to (or as a consequence of): ence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ; 3 r nce of):

Priysician /Medical Examiner

use as the burial-transit

for

page 2 should be

ours after death.

nerel Director: After this certific: filled in by the funeral director.

To the Hospitel 24 hours a

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**Physician** 

/Medical

Examiner

Director

Completed by Funeral

Be

10a. State

MD

**Funeral** 

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. ent of Heatth and Mental Hygiene. ent: If item 27 Is marked other then "netural", or Items 23e or 28e-f show

Maryland 21215-0036

Baltimore,

other treumetic event, the Medical Examiner must be notified at

Examiner Physician/Medical þ Be Completed Certification: To

IF FEMALE:

23b. Was decedent pregnant

9 Unknown

in the past 12 months?

Hyper lipidemia

25. Was case referred to medical

or Attending Physicien: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

J	b. Due to (or as	a consequence
í	. 1	tensi
l	a Dinheto	-s me
	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at	2 Fetal dea

9 Unknown

3 Ectopic pregnancy leath 5 Other (specify)

23d. Date of delivery Month Day

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. disease

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an

3 Probably 4 □Unknown

200-5

Year

autopsy performed? 2 No 1 ☐ Yes 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

1 Yes 2 No	Hosp	ital: 1 npatient 2	☐ ER/Outpatient	3 🗆 🛭	OCA Other: 4	☐ Nursing H	ome	5 Residence	6 ☐Other (Specify
Z LI Accident	nding estigation	8a. Date of Injury (Month, Day Year)	28b. Time of	М	28c. Injury at Work? 1 ☐ Yes	2 🗆 No	28d.	Describe how inju	ury occurred
3 ☐ Suicide 6 ☐ Co	uld not be	On Diagnot Injury At	hama 6				206	Lagation (Ctract o	and Mumbas as Disa

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide 29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

96.	and title of certif	ier		
	ON.	MD.	HOSPITALI	ST

29

29c. License number 060390

29d. Date signed (Month, Day, Year) 05

C	. Name and address of	person who	completed	cause of	death (Ite	m 23a)	(Type.	Print
ì	V \	,					. ,, .	

RD. JABER HOSPITAL HOEEB 00 31. Date filed (Month, Day, Year) 32. Registres Signature

2005 ▶

PRINCE FREDERICK

State Registrar

Medical

Please Type or Print in Black Indelible Jak Ensure All Copies Are Legible.

Amend 1 tem 1 per phys 8043 5-27-05 K Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Mary C. Genovese Year **Physician** MAY 9, 2005 CENOVESE 3:35 A. MARY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** FREDERICK CATHERINE'S NURSING CENTER EMMITSBURG 8. Date of Birth (Month, Day, Year) APRI . 27, 1925 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** 1 □ M 2 🖾 F Months Days Hours Min. Yrs Director 80 PENNSYLVANIA 165-24-8977 Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 7 ie marked othar then "naturel", or itams 23a or 28a-f show treumetic event, tre Medical Examiner mast ke notified at 1 XYes 2 No Funeral Director FREDERICK MARYLAND FREDERICK 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5617 BROADMOOR TERRACE 21754 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. nent of Health and Mental Hygiene. ant: If item 27 le marked othar then "naturel", or ital 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) U.S. STATE DEPT. FOREIGN SERVICE SEC'Y 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 CARMELLA FORTUNATO DOMINIC GENOVESE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOSEPH GENOVESE/BROTHER 5617 BROADMOOR TERRACE, IJAMSVILLE, MD. 21754 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 【☐ Removal from State ō Department of Important: If eny injury or once. ST. ANTHONY CEMETERY 4/14/2005 \* 4 □ Donation 5 □ Other (Specify) WINDBER, PA. 15963 22. Name and Address of Facility 21. Sign yur, of Funeral Service Licensee SKILES FUNERAL HOME 210 W. MAIN ST., EMMITSBURG, MD. 21727-0427 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest physics, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) EPS 18 **Physician** /Medical Que to (or as a consequence of): **Examiner** llomon: Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed 10111C Due to (or as a consequence of) Box 68760. Physiclan/Medical as the l IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day 4□Pregnant at time of death 5 Other (specify) O detached 9 Unknown 9 Unknown signed by it Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ Records, 1 🔲 Yes 2 No 3 Probably 4 Unknown Completed 999 nis certificate has burnector, page 2 st 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 2/2\No Vital F 1 ☐ Yes 25. Was case referred to medical examiner? Physician: Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🎇 No 0 2 ER/Outpatient 3 DOA 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Hospital or Attending 1 X Natural 5 Pending investigation 1 Tes 2 Accident Director: 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To tha Funerel D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 09-2001 se of death (Item 23a) (Type, Print) 3 OR WIEL-

DHMH 17 Rev 1/2001

State Registrar Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Clarence Gregory April 25 2005 4:10 pm /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Calvert County Nursing Center Prince Frederick Calvert If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1₩ 2□ F 224-14-7801 84 Dec. 11, 1920 Virginia Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 ☑ No Director Calvert Prince Frederick 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 85 Hospital Road U.S.A. 14. Race - American Indian, 20678 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 Yes 2 No Specify: Specify: white Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 operating engineer surveying 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Earl Douglas Gregory Mabel Boswell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3145 Catherine T. Gregory, wife Cox Road, Chesapeake Beach, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 04/27/05 Alexandria, VA 21 Senature of Funeral Service Lige 22. Name and Address of Facility Rausch Funeral Home, P.A., Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardiac 5 minutes Cardiovasulas disense Hnerosylenotic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Examiner Records, P.O. Box 68760 Division of Vital

The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit this certificate has I or Attending Physician: after death. Director: After this certific within 24 hours a
To the Funerel C
completely filled To the Hospital

**Funeral** 

Director

28a-f shov

?7 is marked other than "natural", or teems 23e or 28a-f shov traumatic event, the Modical Examinar must be notified at

the Maryland

72 hours after

oe filed within 7 al Hygiene.

permit. Pages 1 and 2 should be lift
Department of Health and Mental Hy
Important: If item 27 is marked oth
any injury or other traumatic event
once.

Pnysician

/Medical

Registrar

Medical

4 T Homicide

29a. Certifier

29b. Signature and title of certifier you unana. 29c. License number D 50653

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4-25-2005

churchton Deale

GYAN - C. SURANA Road Deale

31. Date filed (Month, Day, Year) 32. Registres Signature 2005 ▶

amend item#31,32,perDVR,G843,5/12/05 IT State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) April 26 Day Isabella Gross 2005 **Physician** 4:40 P M /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Calvert 7565 Saw Mill Road Lusby | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Jan. 15, 1915 | 9. Birthplace (State or Foreign Mary Land 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 213-14-9528 90 Yrs. Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State Item 27 is marked other than "natural", or Iteme 23a or 28a-1 shov other traumatic event, it a Madical Examinar must be notified at 1 Yes 2 No Director Maryland Calvert Lusby 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20657 USA 7565 Saw Mill Road Funerai 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🕅 No Specify: Black þ 3℃ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Maryland 2121 Pages t and 2 should be filed within nent of Health and Mental Hygiene. ant: if item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Someone Else's Domestic <u>Home</u> 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Titus Elizabeth Brown Jim 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health and Importent: If Item 27 is many injury or other traum Lusby, MD 20657 Belinda Adams/Daughter 7565 Saw Mill Rd. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Solid Rock Chr.Cem.4/30/05 | Port Republic, MD 22. Name and Address of Facility Sewell Funeral Home 21. Signature of Funeral Service Licensee, Mady Q. 1451 Dares Beach Rd. Prince Fred.,MD20678 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Cossessin **Physician** resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner and Due to (or as a consequence of): physician at s the burial-1  $(\mathcal{ALL}_{\mathcal{L}}\mathcal{A}+\mathcal{Z})$ Division of Vital Records, P.O. Box 68760, Physician/Medical as the attending IF FEMALE: esn. 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ঠ in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown ate has been signed by page 2 should be detach Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Mass 4 Unknown 3 Probably 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes No 24a Was an autopsy performed?

1 Yes 2 No this certificate has funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 🗆 Nursing Home 1 ☐ Yes 2 No ome 5 Residence 6 Other (Specify)
28d. Describe how injury occurred 2 1 Inpatient 2 ER/Outpatient 3□ DOA 28b. Time of 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: After or Attending 1 Natural 5 Pending Injury 1 Tyes 2 No within 24 hours after death. To the Funeral Director: A 2 Accident investigation the 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 4/27/05 DO0 27189 W 30. Name and address of person who commeted caus of death (Item 23a) (Type, Print) Solomon's Island Rd turdinatown ahin Yousaf M.D 31. Date filed (Month, Day, Year) 32. Register State APR 2 7 2005 Registrar

**ORIGINAL** 

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			Amend 1 - State It Registrar	State of cems 23a,	Marylan PtI,II	d / Depa , 25, 27	artment of H	ealth an Jealn'	d Mental Hy 845 <b>,</b> 07/19	giene 705dhb Reg. No.	16149
	Physici	an	1. Decedent's Name (First, Middle, L Ellsworth	ast)		Gros	5		2. Date of De Month	Day Y	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, gi				4b. City, Town, or	Location of D	April Death	18, 200 4c. County of	
	LXamin		Calvert Memori	al Hosp	ital		Prince			Calv	rert
	Funeral Director		5. Social Security Number 220-54-1518  Usual Residence of Decedent	Sex 7 1 M/M 2 □ F	. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. 8. Date of Bir (Month, Da Feb. 1	th Year) 952	9. Birthplace (State or Foreign Country) Maryland
	yland how		10a. State 10b. County		10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
	8a-fs	Director		vert		]	Lusby				1 ☐ Yes 2X No
	3a or 2		10e. Street and Number 985 East Ch	urch Roa	ad		10f. Zip Code 206	57		10g. Citizen of Wh	at Country?
36	within 72 hours after death with the Maryland liene. I then "natural", or Items 23a or 28a-f show The Medical Examinational Lecindilled at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Deced Armed Ford 1 Tyes 2 If Yes, Give Year or Dat	es? !∐XNo		Was Decedent of Hi f Yes, specify Cubai 1 ☐ Yes 2 🔏 No	spanic Origin n, Mexican, P Specify:	? (Specify Yes or No Puerto Rican, etc.)		American Indian, White, etc. Black
Baltimore, Maryland 21215-0036	within 72 hou ene. than "natura	Completed	15. Decedent's E (Specify only highest g	Education		(Give	dent's Usual Occupa kind of work done o DO NOT use retired	lurina most of	working	16b. Kind of Busi	ness/Industry
212	filed with Hygiene other the	Com	12				Foreman				ruction
and	be d it at	To Be	17. Father's Name (First, Middle, Las Theodore	(1)	Gro	oss		Mari	Name (First, Middle,	, <i>Maiden Sumame)</i> Sutto	
ary	2 should and Men is marke aumatic		19a. Informant's Name/Relationship		-	19b. Mailir	ng Address (Street a	and Number o	r Rural Route Numb	er, City or Town, St	ate, Zip Code)
€,	ges 1 and 2 should tof Health and Mer If Itam 27 is marke or other traumatic		Sheena Estep/S	ıster	20h B	. 6	Hilltop sition (Name of	Road	Edgew Date	vater, M	
nor	Pages 1 nent of H int: If its iry or ot		20a. Method of Disposition  1 XBurial 2 Cremation 3  4 Donation 5 Other (Spec		ato C	emetery, crer	God Cem		23/2005		
Baltir	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Lice	-	10						Home red.,MD20678
	Pnysician /Medical Examiner	10	23a. Part1. Enter the disease, or corshock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any leading to immediate	aDue to (o	rasa cons	oxic E	ncephalop	mathy w	rdiac or respiratory a rith compl A y y y y y food by	ications	Approximate Interval Between Onset and Death
,0928	icate be executed physician and s the burial-transit	dicai Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to lo	r as a conseq	uence of):	decody. Fr	3	1 / mg	- Kenlis	10 days
O. Box 6	death certifi e attending id for use as	hysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□ Pregnai 9□ Unknov	th 2 ⊡Feta nt at time of d vn	ll death 3□ leath 5□	Ectopic pregnancy Other (specify)		POROVED BY MEDICAL	EXAMINES d. Date of Month	of delivery n Day Year
ords, P	w requires that the been signed by th should be detache	ted by P	Part II. Other significant conditions	contributing to dea	th but not res	ulting in the u	nderlying cause give	ERW I.	238. Dig t	obacco use contrib	ute to the cause of death?
Vital Records,	The law ate has b page 2 sl	Complet	Och tophocal	<del>t ve</del> ,	tore-	₹			24a. Was autor perfo 1 ☐ Yes	osy prid	re autopsy findings available or to completion of cause of ath?  Yes 2 D No
ita	Phys cian: T this ertificat ral director, pa	o Be	25. Was case referred to medical examiner?	Hospital:	antions 2	ED/Outpaties	Othe	AC:	Death (Check only o		(Consider
on of	E fe a	-	27. Manner of Death  To Natural  Description  To Natural  Description  To Natural   28a. Date of (Month)		28b. Time of Injury	28c. Injury Work	4 1 1401511		how injury occurred  on food		
Division	spital or Attanding burs after death. arai Director: After filled in by the fune	Sertification:	3 Suicide 4 Homicide 6 Could not determine	be 28e. Place o	of Injury - At ho g, etc. (Specif	ome, farm, str	eet, factory, office		City or Tol	wn, State)	or Rural Route Number,
	in 5 m ii	edicai C	(Check only 2 Medical Exa	miner: On the bas	is of examina	wiedge, death	n occurred at the time vestigation, in my op	e, date and p	lace, and due to the occurred at the time,	cause(s) and mann	er as stated.
	To the Hos within 24 ho To tha Funa completely f	Med	one) 29b. Signature and title of certifier	and manne	er stated.		29c. License			29d. Date signed (	
	⊢ s ⊢ ŏ			SPITALIS	T, M	9	960	390		4/18/	105
	4		30. Name and address of person who	1.0		23a) (Type,		Pa	NCE FR	FOGAL	mg 20678
	Sta Registr		31. Date filed (Month, Day, Year)	, , ,	gistra s Signa	ture	docile	1		- 0.001 C V	, , , , , , , , ,

			1 - For State Registrar	State of Marylar		artment of H		d Mental Hy	giene Reg. No. 005	16150		
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of De Month	aath Day Yea	3. Time of Death		
	/Medic	cal	Ralph E. Green  4a. Facility Name (If not institution, give			4b. City, Town, or	Logation of C	March	4 200 4c. County of De			
1	Examin	er	The John Hopkins H			Baltimor		De atti	Baltimo			
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24	Hrs. 8. Date of Bir Min. (Month, Da		hirthplace (State or Foreign Country)		
	Director		139-12-3431	M 2□F 40	Yrs.	Worth's Day's	Tiodis	April	22,1964 Ri	dgewood, NJ		
	land		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	ty, Town or Lo	ocation				10d. Inside City Limits		
	Mary a-f sh	tor	MD Anne Aru	ndel A	nnapo1	is				1 XYes 2 □ No		
	or 28	Oirec	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?		
	s 23a	rail	1107 Lake Heron D			21403	in a contract	2/0	USA	nerican Indian.		
	fter de	Fune	11. Marital Status  1. Never Married 2 Married	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2√ No		If Yes, specify Cuba	in, Mexican, P	? (Specify Yes or No Puerto Rican, etc.)	Black, Wi			
93	ral', o	by	X 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2₩ No If Yes, GiveA Year or Dates:		1□ Yes 2□xNo	Specify:		Specify:	White		
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show fra Modical Examinar must be notified at	Completed by Funeral Director	15. Decedent's Edu (Specify only highest grade		(Give	dent's Usual Occup kind of work done of DO NOT use retired	durina most of	f working	16b. Kind of Busines	s/Industry		
12	within ene. than	duc	Elementary/Secondary (0-12)	College (1-4or 5+)		Officer	1)		Home Funds	s Direct		
<u>5</u>	illed Hygi other	Be Co	17. Father's Name (First, Middle, Last)		Поап	OTTICCI	18. Mother's	Name (First, Middle		J DII CCC		
/lar	Menta Menta arked atic ev	To B	Ralph E. Green Sr	•			Lind	a J. (Spa	ges) Green			
Maryland	2 sho		19a. Informant's Name/Relationship (Ty		-1				er, City or Town, State			
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants if item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event. It's Medical Examinar must be notified at once.		Linda J. Green (1	Mother)	Place of Dispo	sition (Name of		. Apt F2	7. Dover, I			
TOL	Pages ent of it: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 1 ☐ Donation 5 ☐ Other (Specify)	temoval from State		natory or other place ills Memo	1	3/7/05	Dover, DI			
Baltimore,	permit. P Departm Importar any Injur		21. Signature of Fundinal Service Licens	The second secon	and the second second second second	2. Name and Addres			uneral Home			
<u> </u>	99 2 2 8		Manu &	Melin	_ 1:	5522 So.	DuPont		rrington, I			
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused the deat ne cause on each line.	th. Do not ent	er the mode of dyin	g, such as car	rdiac or respiratory a	arrest,	Approximate Interval Between Onset and Death		
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Hepatic Fa						244005		
	Examiner			Due to (or as a consecutive Renal Fui	luence of):					Howeks		
	ليست	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conseq	,					, ve & F3		
	ecuted and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Linhoma						6 weeks		
3760,	death certificate be executed e attending physician and of for use as the burial-transit	Ical E	in south, 2200	Due (or as a conseq		Ostone Wi	CUL			4 weeks 6 weeks 8 weeks		
687	ficate p phys			J. HUNWA W	ALC NOOG	presency vi				00000.		
Вох	leath certific attending pl	Physician/Med	23b. was decedent pregnant	:3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		Ectopic pregnancy			23d. Date of d	,		
П	e deal the att	sicis	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of o		Other (specify)			Month	Day Year		
P.0.	res that the de signed by the a l be detached f		Part II. Other significant conditions con	ntributing to death but not res	sulting in the u	nderlying cause give	en in Part I.	23e. Did t	tobacco use contribute	to the cause of death?		
ecords,	uires n sign	d by						1 🗆	Yes 2 No 3 □ I	Probably 4 \Unknown		
CO	law requires as been sign 2 should be	Completed						24a. Was	an 24b. Were	autopsy findings available ocompletion of cause of		
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lon	Attanding F r death. actor: After by the funer	atlor	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury		k? Yes 2∐No		,			
Division	l or Attano after deatl Diractor:	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h	ome, farm, str	reet, factory, office		28f. Location ( City or To	Street and Number or i wn, State)	Rural Route Number,		
	Hospital or 4 hours afte Funeral Dir 1619 filled in											
	To the Hospital or Attant within 24 hours after death To tha Funeral Diractor: completely filled in by the	edical	29a. Certifier 1 \(\bar{\mathbb{N}}\) Certifying Physical (Check only one) 2 \(\bar{\mathbb{M}}\) Medical Exami	sician: To the best of my kno ner: On the basis of examina and manner stated.	owledge, death ation and/or in	h occurred at the tin vestigation, in my of	ne, date and p pinion, death o	place, and due to the occurred at the time,	date and place, and di	as stated. ue to the cause(s)		
	To the h within 24 To the F complete	Me	29b. Signature and title of certifier			29c. License	e number		29d. Date signed (Moi	nth, Day, Year)		
			> Samuel	WD			-000		April 28	,2005		
			30. Name and address of person who co			Print)		11.1C. c.t	Baltimore			
	Sta	ato.	31. Date filed (Month, Day, Year)	J	ature 1	SPITAL G	00 N.	vooik 21.	196 ITIMINE	MD 2128-4		
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			State of Maryland  State of Maryland  State of Maryland  Per verb., 6843,05/2	/ Depa 27/03d	rtment of Holificate of L	ealth and Death	d Mental Hyg	iene 05	6151
			Decedent's Name (First, Middle, Last)				2. Date of Deat	th David	3. Time of Death
	Physicia /Medic		Howard Hill				April 27	, 2005 Year	10:30a.m♪
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of De	ath	4c. County of Dea	
			Abbey Manor Assisted Living  5. Social Security Number 6. Sex 7. Age (In yrs. Ia	et hirthday)	LaPlata If Under 1 Year	If Under 24 H	rs. 9 Date of Birth	Charles	thplace (State or Foreign
	Funeral Director		152–24–7225 X M 2 F 95	Yrs.	Months Days	Hours M		1910 Bu	Igaria
			Usual Residence of Decedent					,	
	arylan show	_	,	Town or Lo					10d. Inside City Limits 1 ☐ Yes 2X No
	Ba-f s	Director		njemo					
	with ti		10e. Street and Number		10f. Zip Code	2	1	0g. Citizen of What Co	ountry?
	leath ns 23	Funeral	8105 Bowie Road  11. Marital Status  12. Was Decedent Ever in U.S	. 13. \	2066:		(Specify Yes or No-	14. Race - Ame	erican Indian,
9	within 72 hours after death with the Maryland ene. than "natural", or itams 23a or 28a-f show the Modical Exactinat mental be notified at		Armed Forces?  1 ☐ Never Married 2 ☐ Married 1 ☐ Yes. 3 ☐ No If Yes, Give	1	f Yes, specify Cubar 1 ☐ Yes 2☐No	n, Mexican, Pu Specify:	(Specify Yes or No- erto Rican, etc.)	Black, White Specify: Wh	•
8	urai',	d by	3X Widowed 4 Divorced Year or Dates:						
7	nati	lete	15. Decedent's Education (Specify only highest grade completed)	(Give	lent's Usual Occupa kind of work done d DO NOT use retired)	uring most of v	vorking	16b. Kind of Business	/Industry
12	withii iene. than	Completed	Elementary/Secondary (0-12) College (1-4or 5+)		struction			Constructi	on Co.
<u>0</u>	be filed within 72 hc tal Hygiene. d other than *natu	BeC	17. Father's Name (First, Middle, Last)			18. Mother's N	lame (First, Middle, M	Maiden Sumame)	
Baltimore, Maryland 21215-0036		To B	Unknown			Unkr	nown		
Jan			19a. Informant's Name/Relationship (Type, Print)		•			City or Town, State, .	Zip Code)
o)	1 and 2 Health tsm 27 i		L L		sition (Name of	Ruii, Be	el Alton, I	20c. Location - City or	Town State
פֿב	Pages 1 nent of H int: If its iry or ot		1 Surial 2 ☐ Cremation 3 ☐ Removal from State	metery, crer	natory or other place	May 4,	2005	Clinton, M	
量	nit. Partmer artmer ortant injury		* 4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licenses						aryrana
Ba	permit. Pages 1 an Department of Heal Important: If itsm 2 any injury or othar once.		Model Models	4:	270 Hawth	orne Ro	Home, P.A l., Indian	Head, Md.	
			23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart tailure. List only one cause on each line.	Do not ent	er the mode of dying	), such as card	liac or respiratory arre	est,	Approximate Interval Between Onset and Death
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Вох	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be deteched for use as the burial-transit	Physician/Me	23b. Was decedent pregnant  1 Live birth 2 Fetal of	death 3	Ectopic pregnancy			23d. Date of de Month	liv <b>ery</b> Day Year
o.	the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of dea	ath 5L	Other (specify)				,
۵.	that the ed by th detach		Part II. Other significant conditions contributing to death but not resul	ting in the y	nderlying cause give	n in Part I.	23e. Did tob	pacco use contribute to	the cause of death?
Vital Records,	uires tha signed Id be de	d by	Consistive Heart	ball	me		_ 1 □ Y€	s 2 1 No 3 □ P	robably 4 Unknown
00	w require been si should b	Completed	I terne tanner	U			24a. Was a		utopsy findings available
Re	The lav	шо	(17)0000(0)000				- autops perform 1 Yes 2	y prior to ned? death? 2.2 No 1 ☐ Yes	completion of cause of
		a	25. Was case referred to medical			26. Place of E	Death (Check only on		20110
<u></u>	S S	To B	examiner?  1 Yes 2 Hospital: 1 Inpatient 2 E	R/Outpatier	it 3 DOA Othe	<sup>n:</sup> 4□ Nursin	g Home 5 1 1 Conde	once 6√DOther (Spe	Assisted
			27. Manner of Death  1 ☑ Natural 5 ☐ Pending (Month, Day Year)	28b. Time o Injury	Work	?	28d. Describe ho	ow injury occurred	Living
Sio	Attanding r death. actor: After by the fune	catl	2 Accident investigation	,		res 2 □ No	206 Leasting (Ct	and Mumber of C	wel Davida Alivertas
Division	l or At after d Diraci Jin by	Certification:	4 Homicide determined 28e. Place of Injury - At hor building, etc. (Specify)	ne, tarm, str	eet, factory, office		City or Towr	reet and Number or R n, State)	urai Houte Number,
	To tha Hospital or Attand within 24 hours after death To tha Funaral Diractor: completely filled in by the	Medical C	29a. Certifier (Check only one)  1 Certifying Physicien: To the best of my know 2 Medical Examiner: On the basis of examinating and manner stated	rledge, deatl on and/or in	n occurred at the tim vestigation, in my op	e, date and pla inion, death o	ace, and due to the ca courred at the time, da	ause(s) and manner as ate and place, and due	s stated. e to the cause(s)
	o tha ithin 2 o tha omple	Mec	one) and manner stated.  29b. Signature and title of certifier		29c. License	number	2:	9d. Date signed (Mont	h. Day, Year)
}	⊢ 3 ⊢ ŏ		> mit afect		DO	001	031	4/28	115
(			30. Name and address of person who completed cause of death (Item	23a) (Type,	Print)	0 04 1	201	11-0	<u> </u>
1	88			2070	Old Line	Center,	Waldorf,	Maryland	20604
	Sta	ate	31. Date filed (Month, Day, Year)  APR 2 9 2005  32. Registrar's Signate		1				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 04/25/2005 10:30 AM Mary C. Halterman /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Atlantic General Hospital Worcester Berlin If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 06 / 13 / 1923 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 ☐ M 2 😿 F PA 81 178-16-0146 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a. State 10b. County or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No MD Worcester Director Ocean Pines 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number **USA** 11 Duxbury Road 21811 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 XNo Baltimore, Maryland 21215-0036 White Specify: Specify: If Yes, Give Year or Dates: þ 3XWidowed 4 □ Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) f Health and Mental Hygiene. College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Edward Kraft, Sr. Myrtle I. (unknown) 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11 Duxbury Road Ocean Pines, MD 21811 Kathy A. Shock (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If Ite any injury or ot 1 Burial 2 Cremation 3 Removal from State White Rose Crematory 04/29/2005 York, PA \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Burbage Funeral Home 21. Signature of Funeral Service Licenses Part : Enter th-disease, or or molic shock, or heart a lure. List or cau jedithe feath. 108 William Street Berlin, MD 21811 o not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death imediate Cause (Final Oke **Physician** resulting in death) /Medical Due to (or as e consequence of) Examiner Sequentially list conditions, it is a property to a sequence of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be executed 4/25/3005 Box 68760, and Due to (or as a consequence of) signed by the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 1 Live birth 2 Fetel dea 4 Pregnant at time of death 3 Ectopic pregnancy 2 Fetel death Month Day Year 5 Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ of Vital Records, 2 **U**No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 1 No 1 ☐ Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 27. Mann Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending Division 1 ☐ Yes 2 ☐ No death. investigation 2 Accident in by the Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funerel Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ealthing Dr Berlin 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2005

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 27 2005 9:20 PM April Beverly Jeanne Heil /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Cecil E1kton Sun Bridge Nursing Home If Under 1 Year If Under 24 Hrs 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1□M 2XF Yrs Director 65 July 13,1939 Maryland 212 36 0765 Usual Residence of Decedent the Merylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes ŽŽNo Directo Maryland Cecil North East 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with Funerai 404 Champlain Road 21901 United States permit. Peges 1 end 2 should be filed within 72 hours efter deal Department of Health end Mentel Hygiene. Important: If them 27 is marked other them any injury or other trainment. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ঐ No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify 2 Specify 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Vice President of bank Financial 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Glenn McCullough Goldie Mae Dugan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 404 Champlain Road, North East, Maryland 21901 Carroll Heil/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mayerdale Crematory 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State April30 Newark, Delaware 4 ☐ Donation 5 ☐ Other (Specify) 2005 21. Signature Funeral Service Lies see 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, Maryland 21901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Physician/Medical Examiner The law requires that the deeth certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, attending physicien for use es the burie Due to (or as a consequence of) 98 signed by the aid Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23b. Did tobacco usa contribute to the cause of death? 1 ☐ Yas 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? hes 2 No 1 Tes 1 ☐ Yes 2 No certificate or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: A Nursing Home 5 - Residence 6 - Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After this funerel 28a. Date of Injury (Month, Day Year) 27 Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred edicai Certification: Natural 2 Accident 5 ☐ Pending death. investigation 1 ☐ Yes 2 ☐ No Director: / 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours of To the Funeral DI completely filled in To the Hospital to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and tithe of certifier 29d. Date sighed (Month. Day. Year) 29c. License number asmas 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7/0NDO THOMA Registrar's Signature 31. Date filed (Month, I Day, Year) 2 9 2005 State Registrar

			For State Registrar			State o	f Maryl	and / Dep <i>Ce</i>	artmen rtificat			and M	ental Hy	giene		Ō	6 1	54
	Physici	an	1. Decedent's Name	e (First, Middle	e, Last)								2. Date of De Month	Day		'ear	3. Time o	f Death
	/Medio	cal	Virginia E				- 61		11 03	T		(5)	April 2				1040	P M
	Examir	ier	4a. Fecility Name (I								Location of derick			1	. County of alvert			
	Funeral		5. Social Security N	lumber	6. Sex	Certer		rs. last birthday	If Under	1 Year	If Under	24 Hrs.	8. Date of Bir	th	9	). Birthp	lace (State	or Foreign
	Director		214-28-1928	3	1 🗆 N	/ 2 <b>X</b> F	<b>7</b> 6	Yrs.	Months	Days	Hours	Min.	May 27	1928		County.	land	
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	the r	Director	10e. Street and Nu						10f. Zip	Code				10g. Cit	izen of Wh	at Coun	itry?	
	th with	al Di	2350 Solle	ers Whari	E Road	l				206	57			Unit	ed Sta	tes		
920	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. I then "neturel", or items 23a or 28e-f show item 27 is marked other then "neturel", or items 23a or 28e-f show other treumatic event, the Medical Examinat must be notified at	by Funeral	11. Marital Status 1 □ Never Marr 3 ☑ Widowed		ried	. Was Dece Armed Fo 1 Tes If Yes, Giv Year or D	2 <b>XN</b> o	n U.S. 13.	Was Deced If Yes, spec		spanic Orig n, Mexican Specify:	gin? (Spe i, Puerto I	cify Yes or No Rican, etc.)	)-	14. Race - Black, Specify:	White,	etc.	
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Maryland 21215-0036	and 2 sho ealth and I n 27 Is me		19a. Informant's Na Carol Kacha										Route Numb , MD 206		r Town, St	ate, Zip	Code)	
Baltimore,	0 0		20a. Method of Dis 1 Burial 2 4 Donation	Cremation		noval from	State	b. Place of Disp cemetery, cre	matory cr o	ther place		il 30	ate 2005		ocation - Ci	-		
Balti	permit. Pag Department Importent: I any injury o			21. Signature of Funeral Service Licensee  22. Name and Address of Facility  Rausch Funeral Home  4405 Brrows Is. Rd. Port Republic MD 20676  23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate														
The second	Pnysician /Medical Examiner	ner	23a. Part1. Enter t shock, or hea Immediate Cause disease or condition resulting in death)  Sequentially list confirmed in the family leading to incause. Enter Under Cause, (Disease or Cause, (Disease or	rtfailure. List (Final on	complicationly one	Due to	ach line.	eath. Do not en  Intracered sequence of):	ter the mod	e of dying	g, such as	. Por cardiac o	t Republ r respiratory a	ic M	20676		Approximat Interval Bat Onset and SEVEL'A	ween
Box 68760,	death certificate be executed e attending physician and nd for use as the burial-transit	Physician/Medical Examine	resulting in death)  IF FEMALE: 23b. Was deceden in the past 12	t pregnant	d	. If yes, out	come of pre	etal death 3	⊒Ectopic pr						23d. Date o		•	Year
o.	0 0	iysic	1 ☐ Yes 2 9 ☐ Unknown	No		9□ Unkno	ant at time o	or death 5	☐ Other (sp	өспу)								
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Division	P dir	Certification:	3  Suicide 4  Homicide	6 □ Could determ		28e. Place buildi	of Injury - Ang, etc. (Sp.	at home, farm, st ecify)	reet, factory	, office		2	8f. Location ( City or To	Street an wn, State	d Number (	or Rura	Route Num	ber,
	e Hospitel 24 hours a e Funeral I	edical (	29a. Certifier (Check only one)	Certifyin 2 Medical	g Physic Examine	r: On the b	best of my asis of exam ner stated.	knowledge, deal nination and/or in	h occurred ivestigation,	at the tim in my op	e, date and inion, deat	d place, a h occurre	nd due to the	cause(s) date and	and mann place, and	er as sta due to	ated. the cause(s	)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2005 Richard Odell Haffer Apr. 22 2:45 p <sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 307 South Drive Severna Park Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) **Funeral** Days 1**⊠**M 2□F 70 Yrs. Director 217-30-4643 8, 1935 Apr. Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 is marked other then "naturel", or items 23a or 28e-f show other treumatic event, the Newficul Example must be notified at Completed by Funeral Director 1 ☐ Yes 2 XNo MD Anne Arundel Severna Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 307 South Drive 21146 USA 12. Was Decedent Ever in U.S. Amed Forces? 195 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 11. Marital Status 1957filed within 72 hours after 1X Never Married 2 ☐ Married White Baltimore. Maryland 21215-0036 1959 1 ☐ Yes 2 ☒ No Specify: Specify 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Hygiene. CSX Railroad Accountant Pages 1 and 2 should be filed nent of Health and Mental Hygisht: If item 27 Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Odell Stone Haffer Mary Annie Haffer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard K. Benfer, Jr./Friend 307 South Drive, Severna Park, MD 21146 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Apr. 25, 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State ŏ permit. Page Department of Importent: If eny injury or Baltimore, MD Metro Crematory 4 ☐ Donation 5 ☐ Other (Specify) gnature of Funeral Service L Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 26. Part1 Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Φnset and Death Immediate Cause (Final disease or condition region ting in death) Physician mos /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Physician/Medical Examiner Hospital or Attending Physicien: The law requires that the death certificate be executed burial-transit Cause (Disease or Injure that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, use as the JE FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy 1 Live birth 2 Fetal death jo in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?
1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 57 H 1 ☐ Yes 2 ☐ No Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA nce 6 Other (Specify) this filled in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural Injury 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 24 hours after death • Funerel Director: 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Centrying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) use of death (Item 23a) (Type, Print) 33 Name and add

Registrar

State

31. Date filed (Month, Day, Year)

32 Registrar's Signature

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RYAN	M. HOLN	1ES	For State Registrar	State of	Marylan		artment <i>rtificate</i>				lental Hy		005	16	156
- 1			Decedent's Name (First, Middle)	e, Last)			Timodio				2. Date of De				e of Death
	Physic /Medi		Ryan M. Holmes								Month APRIL	22 -	2005	221	5 P M
	Exami		4a. Facility Name (If not institution						Location	of Death		4c.	County of D	eath	
			HOWARD COUNTY					JMBI		OALIe			DWARD		
	Funeral Director		5. Social Security Number	6. Sex 7. 1x M 2 F	. Age (In yrs. i	as <i>t birthday)</i> Yrs.	If Under 1 Months	Days	If Under Hours	Min.	8. Date of Bir (Month, Da Sept.	rth ay, Year) 22 1	19 72	Birthplace (Sta Country)	te or Foreign
		•	030-48-1141 Usual Residence of Decedent								Sept.	22, 1	1974	Massacl	nusetts
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Σ	and 2 salth a		Janine Holmes/	wife		8637	Golde	en S	traw	Ln.	Columb	ia, M	ID 210	45	
Baltimore Maryland 21215-0036	of He of He or oth		20a. Method of Disposition 1 Burial 2 □ Cremation	3 □Removal from St	20b. P	lace of Dispo emetery, crer	sition (Name natory or oth	e of ner place	θ)	D	ate	20c. Loc	ation - City	or Town, State	
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a a	permit. Pages 1 and 2 should Department of Health and Men Importent: If item 27 is marke any injury or other treumatic.		21. Signature of Funeral Service	-1	Si									al Home	e, Inc. 21401
•	Pnysician /Medical Examiner		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a	ased the death th line.	VAC F	er the mode VYTH WITH	MI	7	cardiac o	r respiratory a	rrest,	.apo .a	Approxin Interval I Onset ar	nate Between
8760	icate be executed physicien and sthe burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	С	r as a consequ		00 (7 1)								
P.O. Box 6	death certif e attending d for use a	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No		h 2 ☐ Fetal nt at time of de	death 3	Ectopic pred Other (spec					23	3d. Date of o	delivery Day	Year
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Division of Vital Becords.	is certificate has been si director, page 2 should	Completed by				-					24a. Was autor perfo		24b. Were prior t death	autopsy finding o completion o ? es 2 \( \subseteq \text{No}	gs available f cause of
/ita	Physicien: this certific ral director,	Be	25. Was case referred to medical examiner?							of Death	(Check only o	ne)			
oĘ	Physic this o	2	1 XYes 2 ☐ No 27. Manger of Death	Hospital: 1 ☐ Inp		R/Outpatien			4 🗆 Nui	-	ne 5 ☐ Resid			pecify)	
u	ding I h. After funer	tlon	1 Natural 5 ☐ Pending		Day Year)	28b. Time of Injury	M 280	c. Injury Work	at ? ′es 2.⊟1		8d. Describe l	now injury	occurred		
Divisi	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Certification:	Ž ☐ Accident investig 3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi	not be 28e. Place of	f Injury - At ho , etc. (Specify	me, farm, str		_		- X	8f. Location (S City or Tox	Street and vn, State)	Number or	Rural Route No	umber,
	te Hospital 24 hours a te Funerel l	edical C	29a. Certifier 1 Certifyin (Check only one) 2 Medicel I	g Physicien: To the be Exeminer: On the basi and manner	is of examinat	vledge, death ion and/or inv	n occurred at vestigation, in	the time	e, date and inion, deat	d place, a	nd due to the ed at the time,	cause(s) a date and p	nd manner place, and d	as stated. ue to the cause	e(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	1	11.0				number					nth, Day, Year,	)
				MI	X	-	00	CME				APRI	.L 23	, 2005	
			30. Name and address of person	who completed cause	of death (Item	23а) (Туре,		ם 11	lonn (	Itro-	+ D-1	<b>.</b>	3.6	7 -	04.00
	Sta		31. Date filed (Month, Day, Year)  APR 2	7 2005	istrar's Signat	ure	hade	) )	CIII S	rree	г ват	Llmor	e, Ma	ryland	21201
	Regist	ar	APR &	. 2003		19			7						

			For	lease			rland / Dep	artment of h	lealth and	•		•	e.	16157
			1 - State Registrar				Ce	rtificate of	Death		Reg. No	5.	,	10101
	Physici		1. Decedent's Name (First,	Middle, Li		TURDO	N			2. Date of De Month APRIL	Da Da			3. Time of Death 4:53 PM
	/Medic Examir		4a. Facility Name (If not ins				,-	4b. City, Town, o	r Location of Deat		ara	County of E	-	1 33 1
			UNIVERSITY OF	JARYL	AMO MED	ical u	ENTER	BALTIMOR	E					
	Funeral	Г	5. Social Security Number	6.	Sex		yrs. last birthday	If Under 1 Year	If Under 24 Hrs Hours Min.		rth av. Year.	9.	Birthpla	ace (State or Foreign
	Director		none		1∭ M 2□ F		Yrs.	Months Days	1100.0	Apr 7,	200			l'and
	and *		Usual Residence of Deced			10	c. City, Town or L	ocation	-				10	d. Inside City Limits
	f sho	ō	MD	•				ltimore						112 Yes 2 □ No
	the 1	Director	10e. Street and Number					10f. Zip Code			10a. Ci	tizen of Wha	t Countr	N?
	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "naturel", or items 23a or 28a-f show event, I're Medical Ever it at mast be rigitled at		2203 Bradd:	lsh A	venue				1216			USA		,
	deat	Funerai	11. Marital Status		12. Was Dec	cedent Ever	r in U.S. 13.	Was Decedent of H	lispanic Origin? (S	Specify Yes or No	o-	14. Race - A		
õ	or its		1 X Never Married 2		1 ☐ Yes	2 X No ive		1 ☐ Yes 21 No	Specify:	to ritali, etc.;		Black, V Specify:		
3	urel',	d by	3 Widowed 4 Div		Year or	Dates:							bla ———	
21212-0030	filed within 72 hours after Hygiene. Ither than "naturel", or Ite ant, the Medical Evar-the	Completed	(Specify only		ducation ade completed	)	16a. Dece	edent's Usual Occup e kind of work done DO NOT use retire	ation during most of wo	rking	16b. K	Kind of Busine	ess/Indu	istry
7	with:	m C	Elementary/Secondary (I	)-12)	College none	(1-4or 5+)		none	2/		nor	10		
0	Hygi other ent, I		17. Father's Name (First, N	liddle, Las					18. Mother's Nar	me (First, Middle				
yland	lid be fental rked o	To Be							]	Bridget	Jord	lon		
<u> </u>	shou s mai	-	19a. Informant's Name/Re	ationship	(Type, Print)		19b. Mail	ing Address (Street	and Number or Ru	ural Route Numb	er, City	or Town, Sta	e, Zip C	Pode)
2	s 1 and 2 of Health a item 27 Is other tre		University	of Mc	l Medica	ıl Cen	iter 22	S. Green	Street	Baltimo	re,	MD 21	201	
ore,	ii. Pages 1 and 2 should ertment of Health and Men ortent: If item 27 Is marke injury or other treumatic	12	20a. Method of Disposition 1  Burial 2  Crem	ation 3.	Bemoval from		Ob. Place of Disp cemetery, cre	osition (Name of matory or other pla	ce)	Date	20c. L	ocation - City	or Tow	n, State
Ē	Pages ment of ent: If it ury or o		`4 □Donation 5 🕅 Ot	her (Spec	(fy) in s	tate								
Daltimor	perrit. Pages Depirtment of Importent: If i any injury or once.		21. Signature of Funeral S RONA	dice Lice	Wade	Direct	tor s	2. Name and Addre tate Anat altimore,	ss of Facility Omy Boar	655 W.	Bal	Ltimor	e St	reet
	1511651		3a. Part Enter the disea	se, o con	ni lications had	caused the		iter the mode of dyir	was some				1	Approximate
	Physician		Immediate Cause (Final	i. List only	one cause on	each line.	HEART FA							nterval Between Onset and Death
	/Medical		disease or condition resulting in death)	-	a		nsequence of):	170010	<del></del>					
	Examiner		For exist his section.		Car	NEENI	TAL HEAD	2T DEFEC	T					LI DAYS
	ъ <del>Ц</del>	ner	Sequentially list conditions if any, leading to immediat cause. Enter Underlying Cause (Disease or injury	, J	Due to	(or as a co	nsequence of):							
	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	1	c									
90,	be executed ician and burial-transit	cai E	Tooling III dodn'y Eddi		Due to	(or as a co	nsequence of):							
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ž.	Physicien: The law requires that the death certifical this certificale has been signed by the attending phral director, page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregna	nt	23c. If yes, ou			-	-			23d. Date of	delivery	,
0	death e atte d for	Cia	in the past 12 months 1 2 Yes 2 2 No		4 <u>□</u> Preg	nant at time		□Ectopic pregnancy □ Other <i>(specify)</i> _	<u>'</u>			Month		yay Year
5	it the by the	hys	9 🗆 Unknown		9∐ Unkr	nown					1			
u, L	ss tha	ру Р	Part II. Other significant co	onditions	contributing to o	death but no	ot resulting in the	underlying cause giv	en in Part I.	23e. Did t	obacco	use contribut	e to the	cause of death?
	equire en si ould l		<u> </u>							10	Yes 2	No 3□	Probab	oly 4 ∐Unknown
ב ט	lawr as be	Completed								24a. Was		24b. Were	autops	sy findings available oletion of cause of
_ =	The sate h page	Con								perfo	rmed? 2 M No	death	1?	<b>V</b> No
VII a	cien: ertific ector,	Be	25. Was case referred to mexaminer?	edical				0.11		ath (Check only o	опе)			
5	ohysi this c	2	1 Nes 2 No 27. Vanner of Death				2 ER/Outpatie		4 🗆 Nulsing n	lome 5 ☐ Resi			pecify)	
5	ftei	tion	1 Natural 5 □ !	Pending		of Injury oth, Day Ye	ar) 28b. Time o Injury	Wor	yat k? Yes 2 □No	28d. Describe	now injui	y occurred		
2	Atten deatl ctor: y the	fica	3 ☐ Suicide 6 ☐ €	ould not to	00 000 000	e of Injury -	At home, farm, st	reet, factory, office	163 2 100	28f. Location (	Street an	nd Number o	Rural F	Route Number
2	al or A safter I Dire d in b	Certification;	4  Homicide	1919111111191	build	ling, etc. (S	pecify)	readily, amou		City or To				rodio riambor,
	To the Hospitel or Attending Physicien: The law within 24 burus after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 or	edical C	CHECK ONLY AND INTE	rtifying P dical Exa	miner: On the t	pasis of exa	y knowledge, dea mination and/or ir	th occurred at the tir	ne, date and place pinion, death occu	, and due to the irred at the time,	cause(s)	and manner	as state	ed. ne cause(s)
	o the o the o mple	Med	29b. Signature and little of o		and mar	nner stated.		29c. Licens				te signed (Mo		
	⊢s⊢ő		> 1 X 1	- M				Au 1/13/	435E911					
			30. Name and address one			se of death	(Item 23a) (Type		17) 6477	<i>y</i>	11101	L 28	100	19
			DR. MICHAEL EB	RIGHT	, UMIVERS	ITY OF	MARYLAND	MEDICAL CEM	ER, 22 S.	GREENE ST.	, BA	LTIMURE	MD	21201
	Sta Registr	te ar	31. Date filed (Month, Day,	MAY	1 2 2005	Registrar's	Signature	boarde						
		1 4						1.7						

DHMH 17 Rev 1/2001

ORIGINAL

			1 - State of M	aryland / Depa	artment of Health and rtificate of Death		ene 005	15158
			Decedent's Name (First, Middle, Last)			2. Date of Death		3. Time of Death
	Physici /Medic		Kelvin Arthur Joseph			April 2	Day Year 4, 2005	4:00 P M
^	Examin		4a. Facility Name (If not institution, give street and number, Suburban Hospital	)	4b. City, Town, or Location of Dea Bethesda	ath	4c. County of Death Montg	
	Funeral Director		5. Social Security Number 579 – 50 – 1841 6. Sex 1 M 2 □ F 7. A	ge (In yrs. last birthday) 81 Yrs.	If Under 1 Year If Under 24 Hr Months Days Hours Mir		9. Birth	place (State or Foreign ntry) inidad
	pu.		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	antion			10d Inside Chattain
	shor	'n	Maryland Montgomery	-	er Spring			10d. Inside City Limits 1 ☐ Yes 2 No
	the N	Director	10e. Street and Number		10f. Zip Code	100	g. Citizen of What Cou	
	with Ba or		625 Kenbrook Drive		20902	100	USA	THI Y
	Jeath Tris 20	Funeral	11 Marital Status 12. Was Decedent	Ever in U.S. 13.	Was Decedent of Hispanic Origin? (	Specify Yes or No-	14. Race - Ameri	can Indian,
336	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 le marked other then "neturel", or items 23a or 28a-f show proportion in the marked other then "neturel", or items 23a or 28a-f show proportion in the marked other then "neturel" or items 23a or 28a-f show proportion in the marked of	by Fur	Armed Forces  1 □ Never Married 2 ☑ ★ larried  1 □ Yes ★ ☑  3 □ Widowed 4 □ Divorced  Armed Forces  1 □ Yes ★ ☑  If Yes, Give Year or Dates:	No	f Yes, specify Cuban, Mexican, Puè 1□ Yes 2ॼt No <i>Specify</i> :	erto Rican, etc.)	Black, White, Specify: B1	
Š	2 hou	ted	15. Decedent's Education	16a. Dece	dent's Usual Occupation	16	bb. Kind of Business/Ir	ndustry
218	en °r	Jple	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or	life.	kind of work done during most of w DO NOT use retired)	orking		
2	ygien ygien t, th	Completed	4	Tead	cher & Coach		Educat	ion
Maryland 21215-0036	ntal H ed oth	Be	17. Father's Name (First, Middle, Last)			ame <i>(First, Middle, Ma</i> a Porter	aiden Sumame)	
چ	hould d Mer marke marlc	To	Arthur Joseph  19a. Informant's Name/Relationship (Type, Print)	19h Mailir	ng Address (Street and Number or F		City or Tourn State 7i	Codo)
	alth an 27 le i		Elsie M. Joseph, Ph.D./ W		Kenbrook Drive,			
altimore,	uges 1 and of He		20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State	1 1	natory or other place) Apr	il 27,	c. Location - City or T	
Ħ	artmer artmer artent injury	. 17	<ul><li>4 ☐ Donation 5 ☐ Other (Specify)</li><li>21. Signature of Funeral Service Licensee</li></ul>				exandria,	Virginia
Ba	permi Depar Impor eny ir	l fi	Hans & Owly	50	Pame and Address of Facility Fancis J. Collins OO University Bly	vd, W, Sil	ver Spring	, MD 20901
			23a. Part1. Inter the disease, or complications that cause shock, or heart failure. List only one cause on each	d the death. Do not ent ine.	er the mode of dying, such as cardia	ac or respiratory arres	t,	Approximate Interval Between Onset and Death
	Physician / /Medical	i y	resulting in death)	hemic 3	stroke			
В	Examiner		Due to (or as	s a consequence of):	notic vasur la	disease	2	
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a consequence on).	TOTAL VILLAGE NO	0.00		
	cuted	Examiner	that initiated events c.					
Ö,	cate be executed physician and the burial-transit		resulting in death) Last Due to (or as	a consequence of):				
8760,	ate b	dical	d.					
9	ding p	/Me	IF FEMALE: 23c. If yes, outcome	of pregnancy				
Вох	that the death certificed by the attending I	Physician/Me	in the past 12 months?	2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)		23d. Date of deliv Month	ery Day Year
o.	the de y the iched	nysic	1 Yes 2 No 9 Unknown 9 Unknown	a anno or doalir o	Cities (Specify)			
<u>α</u>	The law requires that the death certifi ate has been signed by the attending I bage 2 should be detached for use as	by Ph	Part II. Other significant conditions contributing to death	out not resulting in the u	nderlying cause given in Part I.	23e. Did toba	cco use contribute to t	he cause of death?
rds	quire; in sign	q pa	cardiomyopar	hy		1 🗌 Yes	2 No 3 Prol	oably 4 Unknown
Vital Records,	aw requir is been si 2 should	Completed	consistive hear	it for live	,	24a. Was an autopsy	24b. Were auto	psy findings available
Ä	The law cate has page 2 s	Com	resolvations for	LIINE		performe	d? death? No 1 ☐ Yes	mpletion of cause of
/ita	iysicien: Th	Be (	25. Was case referred to medical examiner?			eath (Check only one)		
of V	5 S	2	1 Yes 2 No Hospital: 1 Noati			Home 5 Residence		<b>'y</b> )
ion	ding n. After fune	Certification:	27. Manner of Death  1 Natural 5 Pending (Month, Date of Inj. 2 Accident investigation	ury 28b. Time of ay Year) Injury	28c. Injury at Work?  M 1 Yes 2 No	28d. Describe how	injury occurred	
Division	To the Hospital or Attentwithin 24 hours after deatl To the Funerel Director: completely filled in by the	ertific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of In building, e	jury - At home, farm, str tc. (Specify)	eet, factory, office	28f. Location (Stree City or Town, S	et and Number or Rura State)	al Route Number,
_	spital ours ours		29a. Certifier 1 Certifying Physicien: To the best	of my knowledge, death	occurred at the time, date and place	ce, and due to the caus	se(s) and manner as s	tated.
	To the Hospital or / within 24 hours after To the Funerel Directory Completely filled in D	edical	(Check only one) 2 Medical Exeminer: On the basis of and manner s	of examination and/or in	estigation, in my opinion, death occ	curred at the time, date	and place, and due to	o the cause(s)
	To ti withii To ti	Ň	29b. Signature and title of certifier		29c. License number	29d	. Date signed (Month,	Day, Year)
)	4		· m meansmark	ver mi	MD54720	-	4126/05	
			30. Name and address of person who completed cause of Melissa L. Means-Markwel	death (Item 23a) (Type,		et, Bethes	da, MD 208	14
	Sta Registr		31. Date filed (Month, Day, Year)  APR 2 8 2005	rar's Signature	W			

Joseph, Kelvin 4/24/05 1600

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 9 per fh 6843 5-12-05 vt.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** May Hazel C. Kerner 9:24 AM 2005 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** MEMORIAL ALLEGANY If Under 1 Year | If Under 24 Hrs. HOSPITAL 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Pennsvivania **Funeral** Months Days Hours 1 □ M 2 🖫 F Yrs Director 202-22-5431 82 July 10,1922 Pennsylvia Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10h County 10d. Inside City Limits Show "neturel", or Items 23s or 28a-f sh saical Examiner must be notified 1 ☐ Yes 2√2 No Director Harpers Ferry WV Jefferson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Box 86 Blue Ridge Acres 25425 USA death 1 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes. Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 is marked other then "neturel", or Iter 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify:White 3 ₩ Widowed 4 Divorced treumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Housewife Home 17 Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William E. Bloom Mary C. Woodring 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21555 19a. Informant's Name/Relationship (Type, Print) of Health of Item 27 is Dorothy Royer Sister 11301 Blue Grass Farms Lane, Oldtown, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Silbaugh Crematory May 9,2005 = 5 permit. Page Department o Important: If eny injury or once. \* 4 ☐ Donation 5 ☐ Other (Specify) Uniontown, PA 21. Signature of Funeral Service License 22. Name and Address of Facility Hafer Funeral Service, PA Cas 1302 National Hwy., LaVale, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one dause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician MOCARDIAL INFARCTION a POSSIBLE ACUTE disease or condition resulting in death) 45 MINUTES /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physiclan/Medlcal the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by ACCIDENT EREBROVASCULAR 2 100 1 ☐ Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 2 No 1 ☐ Yes of Vital or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ← ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Division 1 X Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by determined 4 ☐ Homicide within 24 hours a 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Certifying Frysham: 10 the best of thy knowledge, usual occurred at the time, date and place, and due to the cause(s) and manner stated.

| Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00033280 2001 30. Name and address of person who complete cause of death (Item 23a) (Type, Print) 5 Dr. SUNIL GUPTA, JOHNSON HEIGHTS MEDICAL Bldg. CUMBERLAND, 31. Date filed (Month State Seem & for Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Day Year ONAld Apri Killmon 7:06A 3 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University of MARY LAND MEDICAL SYSTEM BALTIMONE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Month Day, Year) 34 Birthplece (State or Foreign
 Country) 6. Sex **Funeral** 100M 2□F Director Virginia 219-36-6584 70 Usuel Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or 28a-f show traumatic evant, the Medical Examiner must be notified at 1 Yes 2 No Funeral Director Maryland Dorchester Madison 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Itams 23a 1207 Old Madison Road 21648 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filled within 72 hours after nent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or Its 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No þ Specify. 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Produce Manager Grocery Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be George B. Killmon Alice Sparrow ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Denise K. Wilder/Daughter P.O. Box 1483, Easton, MD 21601 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) MidShoreCremationCenter4/15/2005 Cambridge, Maryland 21. Signature of Funeral Service Licensee Curran-Bromwell Funeral Home, P.A. 308 High St., Cambridge, MD 21613 Ratt Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Sepsis Immediate Cause (Final Physician disease or condition resulting in death) 2 weells /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): The law requires that the death certificate be executed attending physicien and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) the e 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Š Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. cate has been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2 No 1 ☐ Yes 2 ☐ No 1 🗌 Yes Hospital or Attending Physician: 25. Was case referred to medical director 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification; To Inpatient 2 ER/Outpatient 3 DOA 28a. D te of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1-X Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No after death. investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ģ 4 Homicide within 24 hours after To the Funeral Dire completely filled in b , Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

2 8 2005

CAROL MA

South Greave 32. Registrar's Signature

			-	State of Maryla	nd / Depa		lealth and	Mental Hyg	•	16161
	Physici /Medic		Decedent's Name (First, Middle, Last)     Nurbanu		Lalani			2. Date of Deat Month May 4	Day Yeer	3. Time of Death 10:45A.M
	Examir		4a. Facility Name (If not institution, give str 2105 Glen Allen Ave	enue, #101		4b. City, Town, of Silve:			4c. County of Death Montgome:	ry
	Funeral Director			7. Age (In yrs	s. last birthday) 85 Yrs.	ff Under 1 Year Months Days	Hours Mi		Year) 9. Birthp Cour 1920 Diu,	elace (State or Foreign etry) India
	Maryland -f show fied at	tor	Usual Residence of Decedent  10a. State  10b. County  Maryland  Montgome		Silver				1	0d. fnside City Limits 1 ☐ Yes 2 ☐ No
	h with the 3a or 28e at be noti	al Director	10e. Street and Number 2105 Glen Allen Ave	enue, #101		10f. Zip Code 209	06		og. Citizen of What Cour United Stat	
036	I within 72 hours after death with the Maryland piene. jiene. Than "natural", or Items 23a or 28a-f show the Madical Examiner must be notified at the Madical Examiner must be notified at	by Funeral	11. Marital Status 12  1 Never Married 2 Married  3 Xidowed 4 Divorced	. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:		Nas Decedent of H f Yes, specify Cub	Hispanic Origin? an, Mexican, Pue Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - Americ Black, White, Specify: In	
Maryland 21215-0036	within liene.	Completed	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)	tion completed) College (1-4or 5+)	16a. Deced (Give life. Housev	lent's Usual Occup kind of work done DO NOT use retire 71fe	during most of w d)	rorking	own home	ŕ
/land	bed ded ded	To Be (	17. Father's Name (First, Middle, Last) Nanji	Rupani			18. Mother's N Pani	ame <i>(First, Middl</i> e, M	Maiden Sumame) (unk)	
	nd 2 sh alth and 27 Is m r traum		19a. Informant's Name/Relationship (Type Parvezo Lalani —sor						City or Town, State, Zip g, Maryland	
Baltimore,	0 0		20a. Method of Disposition  1 ★ Burial 2 □ Cremation 3 □ Rei  4 □ Donation 5 □ Other (Specify)		comptent crar	sition (Name of natory or other pla shington	ce) Cemeter		20c. Location - City or To 5 Adelphi, M	
Balti	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licensee	reward	44	.uu Powae	r Mill F	Road Belts	Home, PA ville, Mary	land20705
1	/Medical Examiner prize	Examiner	23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one fmmediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate Fail III or the cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	REAT production of the product		ng, such as cardi	ac or respiratory arre	ist,	Approximate Interval Between Onset and Death  MONTH
<u> </u>	The law requires that the death certificate be ex tte has been signed by the attending physician , age 2 should be detached for use as the burial	Physiclan/Medical Ex	d.	bue to (or as a consecutive co	nancy tal death 3	Ectopic pregnanc	y		23d. Date of delive Month	ory Day Year
rds, P.	w requires that to be the signed by should be deta	by	Part If. Other significant conditions control	A .		4	ven in Part I.		s 2 No 3 Prob	ably 4 Dunknown
		Completed	_inflammatoey	cotilis					prior to condeath?	psy findings available inpletion of cause of
	ling Phys n. After this funeral di	tlon: To Be	25. Was case referred to medical examiner?  1 Yes 2 No Ho  27. Manner of Death  1 Matural 5 Pending 2 Accident investigation	spital: 1 ☐ Inpatient 2 ( 28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time of Injury	28c. Inju	ner: 4 🗌 Nursing	eath (Check only one Home 5 Deside 28d. Describe ho	nce 6 Other (Specify	·)
É	F Sign	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, str	eet, factory, office	-	28f. Location (Str City or Town	reet and Number or Rura , State)	I Route Number,
	Ho Fur eely	edical C	29a. Certifier 1 Certifying Physic (Check only one)	cian: To the best of my kr r: On the basis of examir and manner stated.	nowledge, death nation and/or in	occurred at the treestigation, in my o	me, date and pla opinion, death oc	ce, and due to the ca curred at the time, da	use(s) and manner as st ite and place, and due to	rated. the cause(s)
ŀ	To tha within 2 To tha complete	Me	29b. Signature and title of certifier	0	un M		57630		May 4, 2005	
	Ì		30. Name an address of person who com Anuradha Arun, M.D.	10301 Georg	gia Ave	Print) Due, #209	Silver	Spring,	Maryland 29	902
· big	Sta Registi	- ,	31. Date filed (Month, Day, Year)  MAY 1 2 2005	32-Registrar's Sign		40				

			1 - For State Registrar	State of Maryla	-	artment of I			giene Reg. No	05	16162
	Physici /Medio		Decedent's Name (First, Middle, Las     Grace Virginia	Dohr				2. Date of De Month April	ath Day 25	2005	3. Time of Death 11:00A M
	Examir		4a. Facility Name (If not institution, give 1407 Quinwood St			4b. City, Town, o		eath		nty of Death	orge's
	Funeral Director		5. Social Security Number 6. Sec 235-62-4379		: last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H	Irs. 8. Date of Bird (Month, Da Jan. 5,	th	9. Birthr	place (State or Foreign ntry) Virginia
	Maryland -f show	tor	Usual Residence of Decedent  10a. State 10b. County  MD Prince G		ity, Town or Lo					1	10d. Inside City Limits
	or 28e	Director	10e. Street and Number	corge b   m	accov11	10f. Zip Code	<del></del>		10g. Citizen	of What Cour	ntry?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if Item 27 is marked other than "natural", or Items 23e or 28e-f show any njury or other treumetic event, the Medical Eventinal runal be rotified at ODGs.	Completed by Funeral	1407 Quinwood Str  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	eet  12. Was Decedent Ever in I Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		207 Was Decedent of I f Yes, specify Cub	dispanic Origin? an, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	- 14.	SA Race - Americ Black, White, ecify:	etc.
21215-0036	ithin 72 hour ne. nen "natural a Medical Ex	npleted t	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	ucation	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of v	vorking		Whi of Business/In	
d 21	filed w Hygier other th	Col	12 17. Father's Name (First, Middle, Last)		Hous	se Wife	18. Mother's N	lame (First, Middle,	Own I		
/lan	Mental Mental arked c	To Be	Robert Evans					nia Godda		,	
ore, Maryland	es 1 and 2 sho of Health and I litem 27 is me r other treums		19a. Informant's Name/Relationship (7)  Gordon Lohr, Son  20a. Method of Disposition  1 🛣 Burial 2 Cremation 3 🛣	20b.	1407		Street	Rural Route Numbe , Hyattsv Date	ille,		and 20783
Baltimore,	permit. Page Department Importent: II any nlury o		*4 □ Donation 5 □ Other (Specify,	Hall	cyon Hil	ls Memoria . Name and Addre	LPark 4/	30/2005 asch's Fu venue, Hy	neral	Home,	
3	Pnysician /Medical		23a. Part1. Enter the disease, or comp shock, br heart failure. List only of Immediate Gause (Final disease or londition resulting in death)	dications ** caused the dearne cause in each line.		-	-				Approximate Interval Between Onset and Death
8760,	death certificate be executed  manual and physicien and of for use as the burat-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a conse		brea	st Co	ancev		(	Oct 03
P.O. Box 68	death certific e attending p ed for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregr 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	al death 3	Ectopic pregnanc	y			Date of delive	ery Day Year
	The law requires that the ate has been signed by th bage 2 should be detache	by	Part II. Other significant conditions co	ontributing to death but not re	sulting in the ur	nderlying cause gr	en in Part I.		_		ne cause of death?
Il Reco	The law re cate has bee page 2 sho	Completed						24a. Was autop perior 1 Yes	sy rmed?	prior to cor death?	psy findings available mpletion of cause of 2 No
Vita Vita	sicien: certific irector,	o Be	25. Was case referred to medical examiner?	Hospital:	7.50	Ott		eath (Check only o			
Division of Vital Records,	To the Hospitel or Attending Physicien: The within 24 hours after death.  To the Funerel Director: After this certificate his completely filled in by the funeral director, page	Certification: To	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju	v at	Home 51 Residence 18 Residence			′)
DIX.	tel or Attendes is after desti	Certific	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Special		eet, factory, office		28f. Location (S City or Tow		mber or Rura	l Route Number,
	To the Hospitel within 24 hours a To the Funerel completely filled	edical	29a. Certifier 1X Certifying Phy (Check only one) 2 ☐ Medical Exam	rsician: To the best of my kn iner: On the basis of examin and manner stated.	owledge, death ation and/or inv	occurred at the til vestigation, in my o	me, date and pla opinion, death oc	ce, and due to the c curred at the time, o	cause(s) and date and plac	manner as st	ated. the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	2 and	7	29c. Licens				ned (Month, I	-
^	(2)		30. Name and address of person tho c	on lileted cause of the fire	m 23a) (Type		1011025	رن	upr	il o	27,2005
2	5		Celeste Bremer, M	2/1		*	1, Wash	ington, D	C		
	Sta Registr		31. Date filed (Month, Day, Year)  APR 2 9 2005	M. Registrar's Sign	ature						

Please Type or Print in Black Indélible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] 5 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** April 25, 2005 9:09 P Lyles Lorraine /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Annapolis Anne Arundel Medical Center | H Under 1 Year | H Under 24 Hrs. | 8. Date of Birth (Month, Day, Y October 26, 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 5. Social Security Number Year, **Funeral** Months 1 □ M 2√2 F 69 Washington, DC 1935 Director 228–11–6117 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show ith and Mental Hygiene. 27 is marked other then "natural", or Items 23s or 28s-f shov traumatic event, the Madical Exeminer must be notified at 1 ☐ Yes 2 2 No Anne Arundel Crofton Marvland Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number TISA 21114 2131 Davidsonville Road Be Completed by Funeral filad within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 🌋 🖾 No If Yes, Give Year or Dates: 1 Never Married 2 Married **Black** Baltimore, Maryland 21215-0036 1 ☐ Yes 2√XNo Specify: Specify 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) In Home Homemaker 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be nent of Health and Mental ant: If Item 27 is marked o Anna Hill James Stewart 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Vincent Lyles / Son 3603 Asher St. Upper Marlboro, MD. 20772 Health Item 27 i other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If It any injury or o 1 Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) May 2, 2005 Clinton, Maryland Resurrection Cemetery 22. Name and Address of Facility 21. Signatural Funeral Service Licenstee 22. Name and Address of Facility George P. Kalas Funeral Home P.A. 6160 Oxon Hill Road Oxon Hill, Maryland 20745 al Approximate Interval Between Onset and Death 23a. Part. Enter the disease, or complications that shock, or heart failure. List only one cause of caused the death. Do not enter the mode of dying, such as cardiac or respiratory arres each line Immediate Cause (Final disease or condition resulting in death) Priysician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2XXNo 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 3 Probably 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas 2 No 1 Yes certificate Hospital or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Inpatient 2 ER/Outpatient 3 DOA 2 1 Tyes 3/2 28c. Injury at Work? 28d. Describe how injury occurred Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: After Injury 1 Natural 5 Pending investigation 2 □ No 1 Tyes death. 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide 24 hours a Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0 ddress of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/200

State

Registrar

31. Date filed (Month, Day, Year)

APR 2 9 2005

Registrar's Signati

			1 - For Amend #19th State Amend #19th Registrar HCHD	, 4-29-(	of Ma pe	ryland/[r FHDR,	Depa <i>Cer</i>	irtment of <i>tificate o</i> a	Health f <i>Death</i>	and M ว่า	ental Hy	gien Reg. No	e •.		
	Physici	an	1. Decedent's Name (First, Mid	dle, Last)							2. Date of De Month	eath Da	ay CU Ye	a	3. Time of Death
	/Media	al	Ray Lynch  4a. Facility Name (If not institut	on give street an	nd number)			4b. City, Town	or Location	of Death	April	27	200 c. County of D		4:13 A <sup>M</sup>
	Examir	er	Vindobona Nurs	*				Braddoc				1	rederi		
	Funeral		5. Social Security Number	6. Sex		(In yrs. last bir		If Under 1 Yea Months Day	r If Unde	r 24 Hrs.	8. Date of Bi	rth av. Year	9.	Birthpla	ice (State or Foreign
	Director		234-30-3203	1 <u>X</u> M 2□	14	77	Yrs.	lilonals Day	Tiodis		Apr 13	3, 1	928 W	est	Virginia
	land		Usual Residence of Decedent  10a. State 10b. Cour	ty		10c. City, Town	n or Lo	cation				-		10	d. Inside City Limits
	Mary Fed.	tor	Maryland Fred	erick		Point	of I	Rocks							1 ☐ Yes 2X No
	th the	Director	10e. Street and Number					10f. Zip Code	1			10g. C	itizen of What	Countr	y?
	23a c		3722 Kanawha A					21777				USA	<u> </u>		
36	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show f.a Mcdical Examinar must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 ★ M 3 □ Widowed 4 □ Divorc	Arme	Decedent E ed Forces? Yes 2 □ N is, Give r or Dates:		1	Vas Decedent of f Yes, specify Cu I □ Yes 2 XN	ban, Mexica	an, Puerto	ecify Yes or Ne Rican, etc.)	0-	14. Race - A Black, W Specify:		tc.
00-	2 hou atura	ted	15. Deced	ent's Education			. Deced	lent's Usual Occ	upation			16b. F	Kind of Busine		
21215-0036	be filed within 72 hc tal Hygiene. d othar than "natu avent, ILE Miscleal	Completed	(Specify only high Elementary/Secondary (0-12		eted) ege (1-4or 5		(GIVe	kind of work don OO NOT use reti	e durina mo	st of worki	ng				
21	illed within Hygiene. othar than rent, It e M	Con			4	Sy	ste	ms Manag	1					on	Technology
Maryland	ould be fil Mental H larked ott	Be	17. Father's Name (First, Middle Gillie Harriso								(First, Middle : Harle		n Sumame)		
Z Z	should be nd Menta marked umatic av	ç	19a. Informant's Name/Relatio		<i>t</i> )	19b	Mailin	g Address (Stre					or Town Stat	e Zin (	Code)
Ma	a sa		Susan B. Lynch		•/		22.4	Kanvba A						-	
ē,	s 1 and 2 of Health itam 27 i		20a. Method of Disposition			20b. Place of	f Dispo	nawna sition (Name of natory or other p	lace)	Aprif	ate 28.	20c. L	ocation - City	or Tow	m, State
altimore,	Pages nent of P ant: If its ury or o		1 ☐ Burial 2 ☐XCrematio 1 ☐ Donation 5 ☐ Other		from State	1		el Crema	- 1		05	0de	enton,	Mar	yland
Balt	permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service	L. He	H	<b>z</b> MO12		Name and Add oing Hon everly I							784 , MD 21029
	Pnysician /Medical Examiner	niner	shock, or heart failure. L Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a	ue to (or as a	e. consequence		Canc	.e=						nterval Between Onset and Death
68760,	icate be executed physician and s the burial-transit	edical Examin	that initiated events resulting in death) Last	d	ue to (or as a	consequence	of):								
O. Box	death certif e attending id for use as	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 1 1	Live birth	of pregnancy 2  Petal death time of death		Ectopic pregnar Other (specify)	су				23d. Date of Month		y Day Year
s, P	es that igned b be deta	by Pl	Part II. Other significant cond	tions contributing	g to death bu	t not resulting in	n the ur	nderlying cause	given in Part	tl.	23e. Did	tobacco	use contribut	e to the	cause of death?
rds	equire en sig ould b	edk	Carebille	بتحساها	ر مد	nebi	+	NAS	erkn	N5.81	1 🗆	Yes 2	2 No 31	Probal	bly 4 ∐Unknown
Record	The law requires that the rate has been signed by the page 2 should be detache	Completed			<u>.</u>						24a. Was auto perfe 1 \( \text{Yes}		prior death	to com	sy findings available pletion of cause of
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medi examiner?	Hospital:						ce of Death	(Check only	опе)	-		
of	hys this al dii	To.	1 ☐ Yes 2 No 27. Manner of Death		1 Inpatie		utpatien Time of	1 3 DOA			ne 5 Resi 28d. Describe			Specify)	
		tlon	1 □Natural 5 □ Pen		(Month, Day	Year)	Injury	W	ork? □Yes 2□		Edd. Describe	now inju	ary occurred		
Division	or Attand after death Diractor: /	Certification:	3 ☐ Suicide 6 ☐ Cou	d not be 28e.	Place of Inju building, etc	ry - At home, fa . (Specify)	arm, stre	eet, factory, offic			28f. Location ( City or To	Street a wn, Stat	and Number of te)	Rural i	Route Number,
jy(	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	Medical C	29a. Certifier 1 X Certifier (Check only one) 1 Medic	ring Physicien: 7 el Examiner: On and	To the best of the basis of I manner sta	examination an	e, death	occurred at the estigation, in my	time, date a opinion, de	and place, a	and due to the ed at the time,	cause(s date an	s) and manner nd place, and	r as stat	ted. he cause(s)
	To the To the comp	×	29b. Signature and title of cert	lier \	7	***		29c. Lice	nse number			29d. Da	ate signed (M	onth, Da	ay, Year)
			- Click	dill ,	hiid			110	2506	2890		Apri	1 28,	200	5
_			Caroline	on who completed	129	610 0	(Туре,	Print)			wick	Mi	200	1 (0	
:-	Sta Regist		31. Date filed (Month, Day, Ye	9 2005	32. Projistra	r's Signature	A	and .							

Amend Trem 10g per FH 6848, 10/19/05dhb. Ensure All Copies Are Legible. 1- State Registrar 23a, Pt. 1, 27 per ME, C848, Pt. 1, 27 per ME, 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Myron Emmanuel Ludvick II 18 2005 1320 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Anne Arundel Hospital Annapolis Anne Arundel | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 11 (Month, Day Year) Social Security Number 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) 1 **3** M 2 □ F Director 125-66-7915 27 New York Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location or 28a-f show 10d. Inside City Limits the Medical Examiner toust be notified at 1 Yes 2 □ No Anne Arundel **Annapolis** Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or items 23a 612 Admiral Dr. Apt. 407 death v 21401 Funerai Arunde1 Anne 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 ₩ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: ģ Specify: 3 Widowed 4 Divorced "natural" **Black** Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Military Officer **US Navy** other traumatic event, 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be flit Department of Health and Mental Hy Important: If Itam 27 is marked oth any injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Sumame) Be Myron Ludvick Bernice Vellez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bernice Ludvick/Mother 180 Magnolia Woods Court, #18C Deltona, FL 32725 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 x Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) U.S.Naval Academy Cem. 4-25-2005 Annapolis, Md. 22. Name and Address of Facility Chambers Funeral Home & Crematorium, P.A. 21. Signature of Funeral Service Legisee PDC M000915801 Cleveland Ave., Riverdale, Md. 20737 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardiomegaly (enlarged heart) Complicating Sickle **Physician** disease or condition resulting in death) /Medical **Examiner** Cell Trait and probable anabolic steroid use Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed and resulting in death) Last burial-t Due to (or as a consequence of) Mit the map M Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 90 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate Yos Yes 2 X No 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 XYes 2 □ No 1 🔀 Inpatient 2 ER/Outpatient 3 DOA this in by the funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred After 28b. Time of 1 X Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deatl To the Funeral Director: 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide t Certifying Physician: To the best of my knowledge death occurred at the time, date and place, and dus to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 0101054497 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Armed Forces Institute of Pathology

DHMH 17 Rev 1/2001

State Registrar 1413 Research Blvd., Rockville, MD 20850

Elizabeth A. Rouse, LtCol, MC, USAF

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 0 0 5

16167

					Cei	tificat	e of	Death		Re	g. No.		101	0 /
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-	Physician /Medical	Hazel Frances	s Lang							Apr.	26,	2005	3:03	am
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	Funeral Director	5. Social Security Number 219–16–3900 Usual Residence of Dacedent	6. Sax 1  M 2	7. Aga (In yrs. k		If Under Months	Days		Min.	8. Data of Birth (Month, Day, Jan. 8,	<sup>Yaar)</sup> 1924	9. Birthpl Coun	ace (State or lry) NJ	Foreign
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	vith the Mary t or 28e-f eh be notherd	MD Ann	ne Arundel			404 7in	Code	Arnol	.d	140	a. Citizen of \	Albat Cours	1 □ Yas 2	2 <mark>∏</mark> No
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/lar	Mental Me	Richard Bridge	9					Una	avail	lable				
an	and hear	19a. Informant's Nama/Ralation	nship (Typa, Print)		19b. Mailir	ng Addrass	(Straa	t and Numb	er or Rure	al Route Number,	City or Town,	State, Zip	Coda)	
	and 2 raith 27 i	Larry Lang/Son	ı					ive, A	rnol		1012			
Baltimore,	nit. Pagas 1 santuant of Ha ortant: If item injury or othe	20a. Method of Disposition 1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (		CE CE	ace of Dispo emetery, crer .en Hav	natory or o	ther pla	ce) cery	A	20 ZO	Glen B	,		
Balt	permit. Pag Departmant Important: any injury once.	21. Signature of Puneral Service	e Licensee							A. Sever y, Sever				
1	Physician	23a. Party Enter the diseas share, or heart failure. Li	or comp cations that of st only ona cause on a	causad tha daath each line.	. Do not ant	er tha mod	e of dyi	ing, such as	cardiac o	or respiratory arre	st,	1	Approximate Interval Between Onset and De	een
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, P.O.	v requires that the death cartificate be associted been signed by the attending physician and should be datached for use as the bunal-transit leted by Physician/Medical Examir	Part II. Other significant condit	s mel	llitu	S , and the un		eusa gr	st		1 🗆 Ye	s 2 No	3 ☐ Prob		Jnknown
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7	Physician: this cartific iral diractor, TO Be	1 Yes 2 No			ER/Outpatier		)A	_		ma 5 🗆 Rasidar			)	
ion	Attending P or death.  octor: After the funerity the funerity the funerity iffication:	27. Mannar of Death  1 Natural 5 Pend 2 Accidant invas	ling 28a. Data (Mon	of Injury th, Day Year)	28b. Tima of Injury	M 2		iry at ork? ]Yes 2□		28d. Describe ho	w injury occur	red		
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	n 24 hound n 24 hound ne Funer plataly fill edical		ing Physician: To the Il Examiner: On tha b and man			estigation,	, in my	opinion, dea		ed at the tima, da	te and place,	and due to	the cause(s)	
	To the Cooperation N	29b. Signatura and titla of certif	ier	90	~	290	. Licen	sa numbar ) 4/0	750	29	d. Data signe	_	· OS	-
		no blame and address of a	n who completed accord	on of death /tto	23a) (T	Drin*)		. / (	, 0 3	#204	,	~	211	08
		30. Name and address of perso	on MI	8601	Vete	ran	5 7	Hal	huh	ay 1	ille	evil	1/e 1/4	10
	State	31. Data filed (Month, Day, Yea	1)	Ragistrar's Signat	ura /	٠		1	1-0	1		- · · /		

			. For	State of Maryland / Department		•	•	
			1 = State Registrar	Ce	rtificate of Death	Reg	1. No. 2005	16168
	Physici	an	Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death
	/Media	al	PATRICK ANDREV		1 1 0 T		29, 2005	6:30A M
	Examir	er	4a. Facility Name (If not institution, give s 2955 MARSH HAWI		4b. City, Town, or Location of Deat WALDORF	n	4c. County of Death	
Q.	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)		8. Date of Birth (Month, Day, Y	CHARL 9. Birthy	place (State or Foreign intry)
	Director		463-96-3007	M 2□F 46 Yrs.	Montris Days Hours Min.	OCT.8,		FORNIA
1	land wo		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	ocation			10d. Inside City Limits
	Mary e-f eh	tor	MARYLAND CHARLE	ES WALDO	RF			1 ☐ Yes 2 XNo
	ith that or 284	Director	10e. Street and Number	AUDO	10f. Zip Code	10g	J. Citizen of What Cou	ntry?
	ath w	rai	2955 MARSH HAWK		20603		U.S.A	
	be filed within 72 hours after death with the Maryland ital Hygiene. A cother than "natural", or ttems 23s or 28e-f ehow event, the Medical Examination in that be molified at	Funeral	11. Marital Status  1 Never Married 2 Married	<ul><li>12. Was Decedent Ever in U.S. Armed Forces?</li><li>1 X Yes 2 □ No</li></ul>	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl	pecify Yes or No- o Rican, etc.)	14. Race - Americ Black, White,	
920	urs af	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates: 1980-2001	1 ☐ Yes 2☐No Specify:		Specify: WH	ITE
21215-0036	72 ho	Completed	15. Decedent's Educ (Specify only highest grade	completed) (Give	dent's Usual Occupation kind of work done during most of wor	rkina 16	6b. Kind of Business/In	
121	within ane. then."	mpl	Elementary/Secondary (0-12)	College (1-4or 5+)	DO NOT use retired)			
о 5	Hygie Other ont,		17. Father's Name (First, Middle, Last)	5+ PENIO	R MILITARY ANA  18. Mother's Nar	LYST A	NTEON CO	RP.
an	should be filed within or Mental Hygiene.  marked other than matic event, the Mental Men	To Be	JAMES ALLEN MUEH	ILENWEC	BEMUA	JEAN DOD	CON	
Maryland	E sa sa		19a. Informant's Name/Relationship (Typ		ng Address (Street and Number or Ru	ral Route Number, C	ity or Town, State, Zic	Code)
é, ≥	ss 1 and 2 of Health ar litern 27 is r other trau		IVONNE MUEHLENWE	EG-WIFE 2955	MARSH HAWK DR			0603
סב	Pages 1 nent of H int: If ite		20a. Method of Disposition  **Durial 2   Cremation 3   Re	emoval from State	matory or other place)		c. Location - City or To	own, State
Baltimore,	그 든 뿐 글	1 1/2	* 4 □Donation 5 □ Other (Specify)  21. Signature of Funeral Service License		N NATIONAL 7-1 2. Name and Address of Facility	1-2005 A	RLINGTON	, VIRGINIA
Ba	permi Depa Impo any ir		> Mulul	0	RAYMOND FUNERA			
	1 7		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the death. Do not ent	EA PLATA, MARY er the mode of dying, such as cardiac	EAND 20 or respiratory arrest	646	Approximate Interval Between
*	Physician		Immediate Cause (Final disease or condition		? Cer cen			Onset and Death
7.	/Medical Examiner		resulting in death)	Due to (or as a consequence of):				
15	*	-	Sequentially list conditions, b.	Due to (or as a consequence of).				
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,09	te be executed ysician and e burial-transit		resulting in death) Last	Due to (or as a consequence of):				
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x 68	feath certificate I attending physi	Physician/Medi	IF FEMALE:	to If you cutoome of programmy				
Вох	eath c attend for us	cian	in the past 12 months?		Ectopic pregnancy Other (specify)		23d. Date of delive Month	Day Year
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S,	The law requires that the death certifica ate has been signed by the attending phrage 2 should be detached for use as the	by P	Part II. Dther significant conditions cont	tributing to death but not resulting in the ur	nderlying cause given in Part I.	23e. Did tobac	cco use contribute to th	ne cause of death?
ord	w require been sig					1 🗆 Yes	2 No 3 Prob	ably 4 Unknown
Records,	has be	Completed				24a. Was an autopsy	prior to cor	psy findings available mpletion of cause of
_						performed 1 ☐ Yes 2		2□ No
Vital	Attending Physicien: The in death. ector: After this certificate he ector: After this certificate he by the funeral director, page	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	ospital: 1  Inpatient 2  ER/Outpatien	Othor	th Check onli one	. Can	
Division of			27. Mannes of Death	28a. Date of Injury 28b. Time of	28c. Injury at Work?	28d. Describe how	e 6 □Other (Specify injury occurred	Y)
Ö	auth. or: Aft	atlo	2 Accident 5 Pending investigation	(Month, Day Year) Injury	M 1 Yes 2 No			
<u>×</u>	of or Attending Phater death.  Director: After the in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, farm, street building, etc. (Specify)	eet, factory, office	28f. Location (Stree City or Town, S	t and Number or Rura State)	l Route Number,
	Hospitel		29a, Certifier 17 tertifying Physi	ician: To the best of my knowledge, death	a cooursed at the time, data and place	and due to the same	-(-)	
	To the Hospitel within 24 hours a To the Funerel Completely filled	edical	(Check only 2 Medical Examin	er: On the basis of examination and/or invalid manner stated.	rectified at the time, date and place restigation, in my opinion, death occur	red at the time, date	and place, and due to	ated. the cause(s)
	To the To the Complet	Me	29b. Signature and title of certifier	10 19. 40	29c. License number	29d.	Date signed (Month, I	Day, Year)
!	b.		porte	M'alle	102+35	1	29 05	
	axl		30. Name and address of person who con	npleted cause of death (Item 23a) (Type, i	Print)	101	V/	
	Sta	10	31. Date filed (Month, Day, Year)	32 Registrar's Signature	ollete he	006	, 70	
	Registr		MAY 1 2 200	5 House It los	a second			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 20, 2005 APRIL 7:40 A M IRWIN MATT.OW /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY ROCKVILLE 10401 GROSVENOR PLACE #1010 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year)
JUNE 3, 1917 9. Birthplace (State or Foreign **Funeral** 1**X** M 2□ F CONNECTICUT Director Yrs 87 100-10-7622 Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Items 23a or 28a-f shov Iter : ust be nutified at ROCKVILLE MONTGOMERY Y Yes 2 □ No MARYLAND Direct 10f. Zip Code 20852 10e. Street and Number 10g. Citizen of What Country? Χij 10401 GROSVENOR PLACE #1010 death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, treumatic event, the Mudicul Examiner? Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married ŏ Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 X No Specify 3 ₩ Widowed 4 Divorced "naturel", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) d 2 should be filed within 7: ih and Mental Hygiene. 7 Is marked other than "n. Elementary/Secondary (0-12) College (1-4or 5+) PRINTER U.S. GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ANNA POLLACK ပ JACOB MATLOW 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Importent: If item 27 Is n any Injury or other treum <u>once.</u> RICHARD GRAUS - NEPHEW 1439 ALDENHAM LANE, RESTON, VIRGINIA 20190 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) KING DAVID 04/29/05 FALLS CHURCH, VIRGINIA Funeral Servi 22. Name and Address of Facility NATIONAL FUNERAL HOME 7482 LEE HIGHWAY, FALLS CHURCH, VIRGINIA 22042 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician CONGESTIVE HEART FAILURE /Medical Due to (or as a consequence of): Examiner ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 physician certificate be Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 1 Live birth 2 Fetal death ģ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. the detached 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy perform 2 No 1 Yes 1 ☐ Yes 2 No Physician: Be 25. Was case referred to medical 26. Place of Death Check onl one examiner? Hospital: 1 | Inpatient Other: 1 ¥ Yes 2 □ No ပ 2 ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 TResidence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Hospitel or Attending Injury 1 Natural 2 Accident 5 Pending death. investigation М 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide 24 hours a e Funerel I 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only only) the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 015236 APRIL 27, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mt 20852 CAPL I. MARGOLIS, MO. 11/25 AGOKVICLE, 31. Date filed (Month, Day, Year) 2. Registrar's Signature APR 2 9 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Date of Death
 Month **Physician** Year 05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner V Ter Prince George's 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Nov. 4, Birthplace (State or Foreign Florida **Funeral 1**X M 2 □ F Months Days Hours Min. Yrs. **Director** 110-38-4073 55 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10b. County r then "neturel", or Items 23s or 28a-f show the Medical Eracinet must be notified at 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Directo Prince Georges Clinton Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7512 Castlerock Drive 20735 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1X☐Yes 2☐No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ If Yes, Give Year or Dates: Specify 3 ☐ Widowed 4 ☐ Divorced **Black** Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If item 27 is marked other then 1ry or other treumatic event, Ite Me Elementary/Secondary (0-12) College (1-4or 5+) 12 Corrections Officer Corrections 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Lizzie Jones John Milling ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7512 Castlerock Drive, Clinton, MD 20735 John Milling - Son 20a. Method of Disposition
1 ☑ Burial 2 ☑ Cremation 3 ☑ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Important: If eny injury or Hampton Memorial 5-1-05 Hampton, Virginia 5 Other (Specify) ໍ 4 🗆 Donatieຄື of uner Service/License Huntt Funeral Home P. O. Box 156, Waldorf, MD 20604 M00053 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. 23a. Part 1. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Enysician UNG llou sima MOC /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-transit or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. by Physician/Medical as the t attending IF FEMALE: nse If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? be 1 Tes 2 □ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 2 🗆 No 1 ☐ Yes 2 L No 1 Yes filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only of Other: Hospital: P 1 Yes 2 H 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 🗋 Nursing Home 5 Mesidence 6 Other (Specify) this 28c. Injury at Work? Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred after death. 1 Matural 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Medical 29a. Certifier I pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) A 010133548 eted cause of death (Item 23a) (Type, Print) 5/01, NAMC BINE

State

Registrar

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			Registrar  1. Decedent's Name (First, Middle,	Last)	Gertificate of	Death	2. Date of Death	g. No.	3. Time of Death
	Physic /Medi		Charles A	. Marshall			APRIL 2	27, 2005	4:05 PM
	Examir		4a. Facility Name (If not institution, 17809 OLIVER SHC	give street and number)	4b. City, Town, 6	or Location of Death		4c. County of Death CHARLES	1 ,
	Funeral Director		217-36-8462	. Sex 7. Age (In yrs. last 12	birthday) If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, )	Year) 9. Birth Cou	place (State or Foreign intry) ShingtonDC
	and and I.		Usuel Residence of Decedent  10a. State 10b. County	10c. City, To	own or Location	1			10d. Inside City Limits
	with the Maryfand a or 28a-f show be notified at	jo	MD Cha						1 ☐ Yes 2 No
	r 28a	Funeral Director	10e. Street and Number	irres Fa	Plata 101. Zip Code		100	g. Citizen of What Cou	untry?
	th with	aiD	7809 Oliver	Shop Road	2064	6		USA	
	r death	ner	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Spo an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
900	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or Items 23a or 28a-1 show amy injury or other treumetic event, the Medical Eraphyshmatics notified at angle injury or other treumetic event, the Medical Eraphyshmatics notified at angle.	b	1 ☐ Never Married 2 📉 Married 3 ☐ Widowed 4 ☐ Divorced	d 1 □ Yes 2√0 No If Yes, Give Year or Dates:	1 □ Yes 2 □XNo				ite
21215-0036	in 72 h	Completed	15. Decedent's (Specify only highest	grade completed)	Ga. Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	pation during most of works d)	ing 16	3b. Kind of Business/Ir	ndustry
212	d with giene.	mo	Elementary/Secondary (0-12)	College (1-4or 5+)	Contracto	r		Electri	ca1
	be file tal Hy d oth	To Be	17. Father's Name (First, Middle, La			18. Mother's Name		aiden Sumame)	
Maryland	2 should be filed withir and Mental Hygiene. Is marked other then eumetic event, I'm Me	ပ္	Charles G. Ma			Edith M			
Mai	d 2 sh th and 7 is n treum		19a. Informant's Name/Relationship	The state of the s	9b. Mailing Address (Street $P.O.~Box~3$				p Code)
	of Health of Health litem 27		Peggy Marshal 20a. Method of Disposition	20b. Place	of Disposition (Name of tery, crematory or other pla			C. Location - City or T	own, State
E O	Pages ient of nt: If it		1 XBurial 2 ☐ Cremation 3 1 4 ☐ Donation 5 ☐ Other (Spe		shall Ceme	)	/05	Marshall	77Δ
Baltimore,	permit. Page Department o Important: If any injury or once.		21. Signature of Funeral Service Lic	censee L.C	22 Name and Addre	SS OF FacilitY ECHOLS	FUNERAL	HOME, P.	Α.
			23a. Part1. Enter the disease, or co	omplications that caused the death. D	P.O. BO	X 567, L	A PLATA	,MD. 206	4.6 Approximate
	Physician		Immediate Cause (Final	ly one cause on each line.	CO. La V. Bankhat an U.C.	1 1- 0	and	"	Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a Due to (or as a output ueno	re of):	xojn	<i>auch</i>		
	Examiner		Sequentially list conditions	b					
	ed sit	iner	Sequentially list conditions, if any leading of introdisting cause. Enter Underlying Cause (Disease or injury that initiated events	Dua to (or as a nonsequenc	(a or)-				
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.O. Box	that the death certifined by the attending of detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal dea 4□Pregnant at time of death 9□ Unknown		у		23d. Date of deliv Month	ery Day Year
Records, P.	9 20 9	ğ	Part II. Other significant conditions	s contributing to death but not resulting	g in the underlying cause gn	ven in Part I.	23e. Did tobad	cco use contribute to t	
COL	≥ □ □	lete					24a. Was an	24b. Were auto	opsy findings available
Re	ysicien: The law is certificate has b director, page 2 sl	Completed					autopsy performe 1 X Yes 2	prior to co	empletion of cause of
Vital		BeC	25. Was case referred to medical examiner?			26. Place of Death		2110 02.63	20110
of <	Physicien: this certific ral director,	2	1X Yes 2□ No	Hospital: 1   Inpatient 2   ER/0		4   Nursing Hor	ne 5□Resideno		MAT SCENE
n c	ding Phy h. After thi funeral	ion	27. Manner of Death 1 □ Natural 5 □ Pending	FON (Month, Day Year)	Time of 28c. Injury	rk?	28d. Describe how	1 1 00	l
Division	Attending r death. ector: After by the fune	licat	2 ☐ Accident investigat 3 ☑ Suicide 6 ☐ Could not	be 200 Place of laive. At have	16:55"	Yes 2 X No	28f Location /Stree	et and Number or Rus	al Route Number
Δ	after after Dire	Certification:	4 ☐ Homicide determine	building, etc. (Specify)	Tam, direct, lactory, office		City or Town, S	State) build	7809 Oliver
	To the Hospital or Attent within 24 hours after death To the Funerel Director: completely filled in by the	edical C	(Check only 2V Medical Ex	Physician: To the best of my knowled aminer: On the basis of examination	ge, death occurred at the tir	me, date and place, a	and due to the caus	se(s) and manner as s	itated.
	thin 2 the or the mplet	Med	29b. Signature and title of certiller	and manner stated.	29c. Licens			. Date signed (Month,	``
)	To To		WAL C	Win M		.M.E			2005
5	B21		30. Name and address of person wh	o completed cause of death (Item 23a	PENN STREET,	BAT:TTMORI	Ε. ΜΔΡΥΙ ΔΝ	ID 21201	
41.	Sta	ite	31. Date filed (Month, Day, Year)	- 4		- HILLION		ID CICUI	
	Registr	ar	APR 2 9	32. Registrar's Signature	7 apertu				

05-02908 Earl L. Marcel RJD

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

L.	Marcel	Ĺ	1 - State Amend Item 23	State of	Maryla per me	nd / Depa G844ce	artmen	t of Ho	ealth a D <i>eath</i>	and Mo	ental Hy	giene Reg. Nö.	005	16172
	Obvojaj		1. Decedent's Name (First, Middle, Las	')							2. Date of De		Acc - Year	3. Time of Death
	Physici /Medic			Marcel_						4	April	26,	2005	2225 P. M
	Examin	er	4a. Fecility Name (If not institution, give	street and nun	nber)				Location o	of Death			County of Deat	h
			12786 Jones Lane 5. Social Security Number 6. Se	~	7 Age (In yrs	. last birthday)	Wald If Under		If Under 2	24 Hrs.	8. Date of Bir	e la	arles	haloos (State of Faraire
	Funeral Director			_M 2□F	57	Yrs.	Months	Days	Hours	Min.	March	Year)	1948 Wa	hplace (State or Foreign untry) Shington DC
	7		Usual Residence of Decedent										23 10 110	on ring con Bo
	arylar show	<u>_</u>	10a. State 10b. County		10c. C	ity, Town or Lo	cation							10d. Inside City Limits
	89-f	ecto	Maryland Charles	-		Wal	dorf							1 Yes 2 No
	with t	Ē	10e. Street and Number				10f. Zip					_	izen of What Co	untry?
	eath	erai	12786 Jones Lane	12. Was Dece	dent Ever in I	U.S. 13 V		0602	enanic Orio	nin? (Snec	cify Yes or No		USA 14. Race - Ame	rican Indian
(0	r Iten	Funeral Director	1 ☐ Never Married 2 💢 Married	Armed For 1 XYes If Yes, Giv	ces?		f Yes, spec	offy Cuban	n, Mexican	, Puerto F	Rican, etc.)		Black, White	e, etc.
<u>8</u>	rel', o	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Giv Year or Da	e ites:		1 □ Yes	<b>X</b> □ No	Specify:				Specify:	White
5-0	within 72 hours after death with the Maryland ans. than "neturel", or iteme 23a or 28s-f show the Medical Examirer must be notified at	Completed	15. Decedent's Ed (Specify only highest grad			16a. Deced	tent's Usua kind of wor DO NOT us	I Occupa rk done di	tion uring most	of workin	g	16b. Ki	ind of Business/	Industry
12	within ane. than	mpi	Elementary/Secondary (0-12)	College (1	4or 5+)								C C	
9	filed Hygid Sther ent, II		17. Father's Name (First, Middle, Last)		3		Mecha		18. Mother	r's Name	(First, Middle		S Goveri	nment
Maryland 21215-0036	lid be lental ked c	To Be	Louis Santon Marc	el					Su	san 1	Porter			
ary	should wand wand wand wand wand wand wand wan	_	19a. Informant's Name/Relationship (7	ype, Print)		19b. Mailir	g Address	(Street a	nd Numbe	r or Rurai	Route Numb	er, City o	r Town, State, Z	Zip Code)
Σ	and 2 salth n 27 l		Jo Ellen M. Marcel	- Wife	+	_12786	Jone	s Lai	ne, W	aldo	rf, MD	2060	02	
Baltimore,	ges 1 of He if Iter		20a. Method of Disposition 1 □ Burial 2 X Cremation 3 □	Removal from S		Place of Dispo cemetery, cren	sition (Nan natory or o	ne of ther place	)	Da	ate	20c. Lo	ocation - City or	Town, State
Ħ.	t. Pag tmeni tent: tent:		' 4 ☐ Donation 5 ☐ Other (Specify		Ηι	intt Cre	emato	ry		-30-0	05	Wald	dorf, MI	)
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. The Interpreted if I term 27 is marked other than "neturel," or I terme 23a or 28e-f show any Injury or other treumatic svent, I're Medical Examiner must be notified at once.		21. Signatury of Funeral Service Licens	120	M00053 س	3   <sup>22</sup>	Name an Huntt	Fune Fune	of Facility eral	Home	dorf 1	MD 20	0604	
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only c	lications that ca	used the dea	th. Do not ent	er the mod	e of dying	, such as	cardiac or	respiratory a	rrest,	3004	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	inte	SUPA	show	- he	me	The	al	_			Onset and Death
	/Medical Examiner		resulting in death)	Due to (	or as a conse	quence of):				9				
		er	Sequentially list conditions, if any, leading to immediate	b. — Due to (	or as a conse	quence of):								
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events											
oʻ	an an arial-tr	Exa	resulting in death) Last	Due to (	or as a conse	quence of):								
8760,	icate be executed physician and the burial-transit	dical		d										
9 x	ding p	/Mec	IF FEMALE:	23c. If yes, outo	ama of propr	20001								-
Вох	that the death certifi ed by the attending detached for use as	by Physician/Me	in the past 12 months?	1 Live bi	nth 2 ☐ Fet ant at time of	tal death 3	Ectopic pro					2	23d. Date of deli Month	very Day Year
0	the d by the ached	hysi	1  Yes 2  No 9  Unknown	9□ Unkno										
٥,	res that igned t be deta	y P	Part II. Other significant conditions co	ntributing to de	ath but not re	sulting in the ur	nderlying ca	ause giver	n in Part I.		23e. Did t	obacco u	ise contribute to	the cause of death?
ğ	w require been sig should b		Ephedrine Use			_					10	Yes 2[	□No 3□Pro	obably 4 Unknown
Vital Records,	a S.C.	Completed									24a. Was		24b. Were au	topsy findings available completion of cause of
		Con									1 Yes	med?	death?	2 🗆 No
Vita	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:					ata.		(Check only o			(
of	<u>a</u> + <u>a</u>	2	1 X Yes 2 No 27. Manner of Death	1 □ Ir	-	ER/Outpatien 28b. Time of		8c. Injury	4 🗀 1907	4.0	e 5 🗌 Reside l			sify)(scene)
on	Attending Phy ir death. ector: After thi by the funeral of	tion	1 Natural 5 ☐ Pending investigation		n, Day Year)	Injury	м	Work?	? es 2⊡N			iow injury	y 00001100	
Division	Atten er deat ector: by the	ifica	3 Suicide 6 Could not be determined	28e. Place	of Injury - At I	nome, farm, str	eet, factory	, office	1 1000	28				ral Route Number,
٥	tel or rs afte al Dir ed in	Certification:	4 - Tiorniado	Dulidii	g, etc. (Spec						City or To	wn, State,	,	
	To the Hospitel or Attentwithin 24 hours after death To the Funeral Director: completely filled in by the	edical	29a. Certifier (Check only one)	sician: To the iner: On the ba and mann	sis of examin	owledge, death ation and/or inv	occurred a	at the time in my opi	e, date and inion, deat	d place, ar h occurred	nd due to the d at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)
	To the within 2 To the Complet	Me	29b. Signature and title of certifier		0.			. License					e signed (Month	
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H	2 1751		30. Name and address of person who o		$\mathcal{O}_{\mathcal{U}}$	om 23a) (Type,	Print) 11	l1 Pe	enn St	t. Ba	ltimor	e, M	Maryland	21201
.17	Sta	te	31. Date filed (Month_Day, Year)	ACA 32. Re	strar's Sign	nature								
	Registr	1.0	APR 2 9 2	בטט	Maria	nature #	park							

			For State Registrar	State of Maryla		rtment of F			2005	16172
			Registrar  1. Decedent's Name (First, Middle, La	ast)	Cer	uncate or	Dealii	2. Date of Dea	eg. No. UUJ th	3. Time of Death
	Physicia /Medic		Lydia	Alice Mc	Connell			April 2	6, 2005 Yea	10:42 A M
	Examin		4a. Facility Name (If not institution, gire			4b. City, Town, o	or Location of Dear		4c. County of De	
			Southern Maryla			Clinto			Prince	
	Funeral Director			Sex 7. Age (In your 1	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		, 1945 Wa	Sirthplace (State or Foreign Country) Shington, DC
	yland now		10a. State 10b. County	10c.	City, Town or Loc	cation				10d. Inside City Limits
	e Mar la-fat	ctor	MD Charl	es	Waldorf					1 ☐ Yes 2X No
	vith th	Dire	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What	Country?
	eath v	eral	902 Truro Lane	12. Was Decedent Ever in	IIS 13 V	20601		Specify Ves or No-	USA 14 Bace - At	merican Indian,
36	perrit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depiritment of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f ahow any injury or other traumatic event, the Medical Eracult er must be notified at once.	by Funeral Director	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1 Yes 2 N No If Yes, Give Year or Dates:		Yes, specify Cubi		Specify Yes or No- to Rican, etc.)	Black, W	
Maryland 21215-0036	72 hou	Completed	15. Decedent's E (Specify only highest gr	ducation	16a. Deced	ent's Usual Occup	pation	rking	16b. Kind of Busines	ss/Industry
2	ithin and "t	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. D	OO NOT use retired	d)			
2	be filed water Hygier Hygier ed othar than avent, In	Co	12 17. Father's Name (First, Middle, Las.	e)	Cou	ncilwoma		me (First, Middle, I	Municipal	Gov't
and	d be f	o Be	Douglas C. Wind					E. Taylor		
Ž	should nd Men marke	ဥ	19a. Informant's Name/Relationship		19b. Mailin	g Address (Street			, City or Town, State	, Zip Code)
	1 and 2 Health a tam 27 Is		James F. McConnel	ll - Husband	902	Truro Lai	ne. Wald	orf, MD	20601	
ore	of He of He If itam		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 [		. Place of Dispos	sition (Name of natory or other plac			20c. Location - City	or Town, State
Ē	Pages tment of tant: If it tury or o		* 4 ☐ Donation 5 ☐ Other (Speci	ify) MD					Cheltenha	m, MD
Baltimore,	perrit. Dep rtr Imports any inji		21. Signature of Funeral Service Dice	manu M00053	3 22	Name and Addre Huntt Fui P.O. Box	neral Ho 156, Wa	ne ldorf, MD	20604-0	156
n	in in the second		23a. Part 1. Enter the disease, or con shock, or heart failure. List only	one cause on each line.	eath. Do not ente	er the mode of dyir	ng, such as cardia	c or respiratory arm	est,	Approximate Interval Between Onset and Death
ш	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. End Sta. Due to (or as a cons	ge Con	gestire h	east 1	ailur-		unknown
g.	Examiner					0				STREET, PRODUCT
		Jer	Sequentially flat conditions if any, leading to immediate	b. See 5 is	sequence of):					and the
	cate be executed physician and the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c.						
8760,	oe execian a	EX	resulting in death) Last	Due to (or as a cons	sequence of):					
876	icate b	edical		d						
Box 6	eath certific attending p for use as I	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre-	gnancy				23d. Date of c	lelivery
m.	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/M	in the past 12 months?	1□Live birth 2□Fi 4□Pregnant at time o		Ectopic pregnancy Other (specify)	y 		Month	Day Year
P. O.	at the by the tache	hys	9 Unknown	9□ Unknown						
	res that the de signed by the a be detached f	by	Part II. Other significant conditions	contributing to death but not i	resulting in the un	iderlying cause giv	en in Part I.			to the cause of death?
Records,	w requir been si should	Completed	Diabeter	•						Probably 4 Honknown
ဒ္ဓင	has t	mpl				-		24a. Was a autops	y prior t	autopsy findings available o completion of cause of ?
		e Co	25. Was case referred to medical				00 Pl(P-	1 ☐ Yes 2	2 1 Y	
$\equiv$	sicia cert irecte	0 8	examiner?	Hospital: 1 Inpatient 2	ER/Outpatient	3 □ DOA Oth		ath <i>(Check only on</i> Home 5∏ Reside	ence 6 Other (Sp	pecify)
	> 0 T3	F +	27. Manner of Death	28a. Date of Injury (Month, Day Year,		28c. Injur Wor	y at rk? Yes 2 □ No		ow injury occurred	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
on of	ding After fune		1 ■Natural 5 □ Pending				103 1			
vision of	ding After fune		1 ■Natural 5 □ Pending 2 □ Accident investigation 3 □ Suicide 6 □ Could not be	28e. Place of Injury - A	t home, farm, stre					Rural Route Number,
Division of Vital	ding After fune	ertification;	1 ■Natural 5 □ Pending 2 □ Accident investigation	on Diago of Injury A	t home, farm, stre			28f. Location (St City or Town		Rural Route Number,
Division of	ding After fune	Certification:	1 Autural 2 Accident 3 Suicide 4 Homicide  29a. Certifier  1 Certifying P	28e. Place of Injury - A	ecify)  knowledge, death	eet, factory, office	me, date and place	City or Town	n, State)  ause(s) and manner	as stated.
Division of	ling After lune	ertification;	1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)  29b. Signature and title of certifier	28e. Place of Injury - A building, etc. (Spe hysician: To the best of my miner: On the basis of examand manner stated.	ecify) knowledge, death ination and/or inv	occurred at the tirrestigation, in my o	opinion, death occi	City or Town	ause(s) and manner ate and place, and d	as stated. ue to the cause(s)
Division of	ding After fune	Certification:	1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)  29b. Signature and title of certifier	28e. Place of Injury - A building, etc. (Spe hysician: To the best of my miner: On the basis of examand manner stated.	ecify) knowledge, death ination and/or inv	occurred at the tirrestigation, in my o	opinion, death occi	City or Town	ause(s) and manner ate and place, and d	as stated. ue to the cause(s)
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DHMH 17 Rev 1/2001

Registrar

APR 2 7 2005▶

			For State Registrar	State of Marylar	nd / Depa		lealth and l	Mental Hyg	•	5 16175
			Decedent's Name (First, Middle, L.	ast)				2. Date of Dea	th	3. Time of Death
	hysicia /Medic		Lillian Sue Mad	ldens				APNIL	Day 21 20	05 6 20 P.M.
	xamin		4a. Facility Name (If not institution, gr			4b. City, Town, or	Location of Death	-	4c. County o	1 1
			North Arunde			Glen	If Under 24 Hrs.		Anne	Hrundel
	neral ector		228-26-4708	Sex 1	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day Aug. 26	7 Year) 5,1928	9. Birthplace (State or Foreign Country)  VA
land	M III	-	Usual Residence of Decedent  10a. State 10b. County	10c. Ci	ty, Town or Loc	ation				10d. Inside City Limits
не Магу	r 280-t show	ector		Arundel			rsville	Т.	10.00	1 ☐ Yes 2 ☒ No
A ( I i.Q.M.) death with the Maryland	23e or 2	ai Dir	10e. Street and Number 248 Nathan Way			10f. Zip Code 211	08		log. Citizen of Wh	usA
r dea	ems er c.	Iner	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13. W	as Decedent of H Yes, specify Cuba	ispanic Origin? (S an, Mexican, Puert	pecify Yes or No- o Rican, etc.)		- American Indian, White, etc.
Macyland 21215-0036 As should be filed within 72 hours after death with the lith and Mental Hygiene.	Examin	Completed by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ∏Yes 2 ☑ No If Yes, Give Year or Dates:		□Yes 2½∏ No			Specify:	White
2 5 5 E	netu	etec	15. Decedent's E (Specify only highest g	ducation ade completed)	16a. Decede	ent's Usual Occup	ation during most of wor	king	16b. Kind of Bus	iness/Industry
<b>12 2 2 2 3 3 3 3 4 3 3 3 3 3 3 3 3 3 3</b>	neu Ma	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)		o not use retired nquette			Holid	lay Inn
A 2 S P P P P P P P P P P P P P P P P P P	other ant, II	ပိ	17. Father's Name (First, Middle, Las	t)				ne (First, Middle,		
ylan ould be	arked c	To Be	Merdith N. Newn				7117	Helen Ly		
Mar nd 2 sh	item 27 is marked other then "neturel", other treumetic event, IT's Moulcul Exa	ı	19a. Informant's Name/Relationship Fred C. Maddens				and Numberor Ru ay, Mill			tate, Zip Code) 108
or He	r othe		20a. Method of Disposition 1 □ Burial 2 ②Cremation 3	Domewel from State		atory or other plac	(e) A		20c. Location - C	ity or Town, State
Baltimore, permit. Pages 1 ar Department of Hea	tent: II jury o		`4 □Donation 5 □Other (Spec	ify) I <sup>V</sup> I		ematory	2	. 26, 005 -	Baltimo	
Balt permit. Depart	Importent: If Ite any injury or ott once.		21. Sign J e of F) eral Service Lice	All	Ba 49	rranco & 5 Gov. R	s Sons, P itchie H	.A. Seve	rna Park rna Park	Funeral Home , MD 21146
			23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final	nplications that caused the dea y one cause on each line.	th. Do not ente	20	A	or respiratory arr	est,	Approximate Interval Between Onset and Death
	ician dical	l	disease or condition resulting in death)	aDue to (or as a consec	7.0h	nenn	MINIA			
Exar	niner		Sequentially list conditions	o dome	nti A	_				
<b>D</b>	is.	iner	Sequentially list conditions, any leading to minimize a cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consul	monda ufir					
<b>760,</b> le be executed	nysician and he burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as a consec	quence of):					
760,	sician buria	caiE		, d	. ,					
687 Lifficate	g phys			0					- Park	
Box	attending phy I for use as the	In/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregn 1☐Live birth 2☐Feta		Ectopic pregnancy			23d. Date	,
. 0	by the att	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of o		Other (specify)			Mont	h Day Year
P.O.	B 8	y Ph	Part II. Other significent conditions	contributing to death but not res	sulting in the und	derlying cause giv	en in Part I.	23e. Did to	bacco use contrib	oute to the cause of death?
ords	should be	ted by						1 🗆 Y	es 200 No 3	Probably 4 Unknown
law r	as be	Completed						24a. Was a	sv pri	ere autopsy findings available or to completion of cause of
<b>E</b> &	certificate has lirector, page 2 s	Con						perform 1 Tes		ath? ]Yes 2□ No
Vita	ector	Be	25. Was case referred to medical examiner?	Hospital: Notice of		3CI DOA Oth	00	th (Check only or		
Of Phys	this ald	To	1 Yes 2 No 27. Manner of eath	28a. ate of Injury	ER/Outpatient 28b. Time of	3 DOA 28c. Injun	4 [] Indising i	ome 5 Reside	ence 6 Dother ow injury occurred	
vision of Vital	ir: After ne funer	atior	1 Natural 5 ☐ Pending investigati		Injury	Wor	k? Yes 2 □ No			
Division of Vital Records, nor Attending Physicien: The law requires talter death.	Director:	Certification:	3 Suicide 6 Could not 4 Homicide determine		iome, farm, stre fy)	et, factory, office		28f. Location (S City or Town		or Rural Route Number,
Di Hospitel or 24 hours afte	To the Funerel Dire completely filled in b	edical C	29a. Certifier (Check only one)	hysician: To the best of my knominer: On the basis of examination and manner stated.	owledge, death ation and/or inve	occurred at the tin	ne, date and place pinion, death occu	, and due to the c rred at the time, d	ause(s) and mannate and place, an	ner as stated. d due to the cause(s)
To the within 2	ro the	Me	29b. Signature and title of certifier		*	29c. Licens	e number	2	9d. Date signed	(Month, Day, Year)
			AA	ms		D4	3977	0	ini 2	1 2005
_			30. Name and address of person who	completed cause of death (Item	m 23a) (Type, P	rint)	/		7	1,0/:
			31. Date filed (Month, Pau Year)	32. Restrar's Sign	mt/	sive 1	Non !	rurino	ims.	4001
	Sta Registr	200	ST. Date libra (Moriti), APR S	2005	1	South !				

			. 101	artment of Health and Me ertificate of Death		giene() ()	5 16176
	D		1. Decedent's Name (First, Middle, Last)		2. Date of Dea		3. Time of Death
	Physici /Medic		Rose Marie D. Ossola		April	28, 200	
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County o	of Death
			Casey House  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	Rockville  If Under 1 Year   If Under 24 Hrs.	8. Date of Birt	Montgo	
	Funeral Director		112-14-5710 1.384 Juniary, 12 1 7. Age (m.y.s. last bininary, 12 1 1 1 1 2 1 1 1 1 1 1 1 1 1 1 1 1 1	Months Days Hours Min.	Jun 12		Birthplace (State or Foreign Country)
			Usual Residence of Decedent	· · · · · · · · · · · · · · · · · · ·	Juli 12	1925	New York
	arylan show	<u>.                                    </u>	10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
	Ba-f	ecto	Virginia Fairfax Alexandri	<del></del>			1 ☐ Yes 2X No
	with t		10e. Street and Number	10f. Zip Code		10g. Citizen of W	nat Country?
	ns 23	Funeral Director	5903 Mt. Eagle Drive #505  11. Marital Status   12. Was Decedent Ever in U.S.   13.	22303 Was Decedent of Hispanic Origin? (Spec	ify Yes or No-	JSA 14. Race	- American Indian,
တ	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or Itams 23a or 28a-f show ant, it a Mudical Exacultant stat be recilified at	Fun	Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ☑ No	If Yes, specify Cuban, Mexican, Puerto R	lican, etc.)	Black	, White, etc.
8	ours a	d by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐XNo Specify:		Specify:	White
2	"natt	Completed	(Specify only highest grade completed) (Give	edent's Usual Occupation e kind of work done during most of workin DO NOT use retired)	g	16b. Kind of Bus	siness/Industry
12	withir ene. than	dmo	Elementary/Secondary (0-12)  College (1-4or 5+)  Homen			Own Home	a
2	filled Hygi other ant, I		17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle,		
a	lid be fental rked c	To Be	Andrew DePaulis	Clementine	e Melil	10	
Maryland 21215-0036	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene is marked other than "natural", or Itams 23a or 28a-f show is marked other than "natural", or Itams 23a or 28a-f show aumatic evant. It a Modified Ext. "ither result be notified at	0 11		ing Address (Street and Number or Rural			State, Zip Code)
Σ	and and and n 27 in 27 in the			Addison St. Berkel			
altimore,	Pages 1 and 2 should b nent of Health and Ments int: If itam 27 is marked iry or other traumatic e			matory or other place)	ite		City or Town, State
<u>=</u>	9 6 6 5		`4 □Donation 5 □Other (Specify) W • AI UII	lel Crematory Apri	005		, Maryland
Ba	permit. Departr Importa any inj			2 Name and Address of Facility Oing Home Cremation Severly L. Heckrotte			
8760,	cate be executed // Medical // Medical in the burial fransit	dical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	nter the mode of dying, such as cardiac or		rest,	Approximate Interval Between Onset and Death
.O. Box 6	The law requires that the death certificat Ite has been signed by the attending phy tage 2 should be detached for use as th	by Physiclan/Medi		□Ectopic pregnancy □ Other (specify)		23d. Date Mont	of delivery th Day Year
<u>a</u>	s that ned by	y Ph	Part II. Other significant conditions contributing to death but not resulting in the t	underlying cause given in Part I.	23e. Did to	bacco use contrib	bute to the cause of death?
rds	w require: been sig should be	ed b	Chronic Obstructive Pulmonary Diseas	e	1 □ Y	′es 2□No 3	3□Probably 4 🖫Unknown
Records,	The law re ate has bei page 2 sho	Completed			24a. Was: autop perfor	sy pri med? de	ere autopsy findings available ior to completion of cause of sath?  Yes 2 No
Vital	ysician: The is certificate hadirector, page	Be (	25. Was case referred to medical examiner?	26. Place of Death	(Check only o	ne)	
ot	Physis this o	은	1 ☐ Yes 2 🛣 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie				(Specify) hospice
u C	ding h. After Auner	lon	27. Manner of Death  1 X Natural 5 Pending (Month, Day Year)  2 Accident investigation	of 28c. Injury at Work?  M 1 ☐ Yes 2 ☐ No	sa. Describe n	ow injury occurre	a
Division of	or Attan	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)		3f. Location (S City or Ton	itreet and Number n, State)	r or Rural Route Number,
	To the Hospital within 24 hours a To the Funeral Completely filled	edical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, dear 2 Medical Examiner: On the basis of examination and/or in and manner, stated.	th occurred at the time, date and place, and exestigation, in my opinion, death occurred	nd due to the o	cause(s) and man date and place, ar	ner as stated, nd due to the cause(s)
	To th within To th compl	Me	29b. Signature and the of certifier	29c. License number	_ :	29d. Date signed	(Month, Day, Year)
)			WHITT -	041218		4/28	105
			30. Name and dress of person was completed cause of death (Item 23a) (Type Charles Harrison M.D. 6001 Muncaster		, MD 2	0855	1 - 1
	Sta Registr		31. Date filed (Month, Day, Year)  APR 2 9 2005  32. Signstrar's Signature	berthe			

	•	For State Registrar	State of Marylan		artment of rtificate of			ieņe <sub>eg. No.</sub> 005	16177
Physicia		1. Decedent's Name (First, Middle, Las JAMES ELLIS	PEARSON				2. Date of Dear	29, 2005	3. Time of Death 6 ! 02 A. M
/Medica Examine		4a. Facility Name (If not institution, give	e street and number)			or Location of Dea		4c. County of Deat	GEORGE'S
Funeral Director		5. Social Security Number 6. S 215-36-4278		last birthday) Yrs.	If Under 1 Year Months Days			9. Birt Co 7,1940 W	hplace (State or Foreign untry) ASH , DC
Maryland -f show	tor	Usual Residence of Decedent  10a. State 10b. County  MARYLAND PRINCE		y, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☐ No.
with the a or 28a be notii	Dire	10e. Street and Number		SEADK	10f. Zip Code	.506	1	0g. Citizen of What Co	
	by Funeral	9526 WORRELL A\ 11. Marital Status  1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U. Armed Forces?		Was Decedent of	) 7 0 6 Hispanic Origin? (S ban, Mexican, Puel D Specify:	Specify Yes or No- to Rican, etc.)	U · S ·  14. Race - Ame Black, Whit	rican Indian,
Lithin 72 len "naf	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation	(Give	DO NOT use retir	during most of wo		16b. Kind of Business/	Industry ON POST
Maryland 21 d 2 should be filed w th and Mental Hygien 77 is marked othar th traumatic evant, ILL	To Be Co	17. Father's Name (First, Middle, Last) JOHN HOWARD PE	_	MAIL	EK		me (First, Middle, I	NEWSPAPE Maiden Sumame) SE GRISS	
Heal Heal Sther		19a. Informant's Name/Relationship (  DOROTHY PFARSON 20a. Method of Disposition  ↓⊟Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif	N - WIFE 20b. F	9526 Place of Disponentery, crea	WORREI esition (Name of matory or other pla	CL AVE.	SEABROC Date	20c. Location - City or	AND 20706 Town, State
Dalitimol permit. Pages Department of Important: If is any injury or ones.		21. Signature of Fyneral Service Licer  23a. Part 1. Enter the disease, or come shock or heart failure. List only	nsee MOO47	9 2	OLN CENT.  Name and Addr  RAYMONI	ess of Facility		BRENTWOO	D, MD
Fnysician /Medical Examiner	ner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to ammediate cause. Enter Underlying Cause (Disease or injury	a. Due to (or as a consequence)	Ince of io	100	ing, such as cardia	~	est,	Approximate Interval Between Onset and Death
6 / 6U, rate be executed hysician and the burial-transit	dicai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a conseq	uence of):					
ath certific titending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	Ideath 3	Ectopic pregnan	су		23d. Date of dei Month	ivery Day Year
w requires that the de been signed by the a should be detached f	þ	Part II. Other significant conditions of	contributing to death but not res	_	nderlying cause g	iven in Part I.		bacco use contribute to es 2 □ No 3 □ Pr	
The law require the law require has been single page 2 should I	Completed						24a. Was a autops perform	y prior to death?	topsy findings available completion of cause of
VICAL:	o Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital: 1 ☐ Inpatient 2 🗹	ER/Outpatie	nt 3 DOA	ther	eath (Check only on Home 5 Reside	ence 6 Other (Spe	cify)
UNUSION OT VITAI  I or Attanding Physician: 1 after death. Diractor: After this certificat d in by the funeral director, p.	ation: T	27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28c. Inju			ow injury occurred	,,
rs rs selle	Certification;	3 Suicide 6 Could not be determined	building, etc. (Specif	(y)			City or Town		
e Hospi 24 hou a Funai letely fil	Medical		nysician: To the best of my kno niner: On the basis of examina and manner stated.						
To th within To th comp	Me	29b. Signature and title of certifier	andrack	0		nse number	_	9d. Date signed (Monti	
1141		30. Name and address of person who	completed cause of death (Iter	n 23a) (Type,	Print)	buy R	d Hua	thrille M	10 20187
Stat Registra		31. Date filed (Month, Day, Year)	32 Registrar's Signa						

			Please	Type or Print in B	lack Inc	delible Ink.	Ensure A	II Copies A	Are Legibl	e.			
			1 - For State Registrar	State of Maryland		rtment of H			iene	5 15170			
			Decedent's Name (First, Middle, La.	st)				2. Date of Deat	h	3. Time of Death			
	Physicia		Milton Harold Po	owell, Jr.				April 3	27, 2005	12:48AM			
	/Medic Examin		4a. Facility Name (If not institution, giv			4b. City, Town, or	r Location of Death	7 9	4c. County of I				
	Exami		Doctor's Communi	Lanham	ı		Prince George's						
	Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs. la	ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	9.	Birthplace (State or Foreign Country)			
	Director		212-34-6649	XDM 2□ F 53	Yrs.	Wildrig Days	110010		1952	Maryland			
	pus *		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10										
	sho	ក	,							10d. Inside City Limits 1 ☐ Yes 2X No			
	28a-1	ect	MD Prince (	seorge's Gre	enbe1t	10f. Zip Code		10	og. Citizen of Wha	t Country?			
	with Sa or	Funeral Director	16 U Ridge Road			2077	Λ		USA	Oddiniy.			
	Jeath	era	11. Marital Status	12. Was Decedent Ever in U.S	S. 13. W	Vas Decedent of H	lispanic Origin? (Sp	14. Race -	American Indian,				
0	after or Ital	Fu	1 X Never Married 2 ☐ Married	Armed Forces?  1 X Yes 2 □ No If Yes, Give			an, Mexican, Puerto		White, etc.				
3	ral', c	i by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:							Specify: White			
5	72 h 'natu	etec	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	(Give I	ent's Usual Occup	durina most of work	ing	16b. Kind of Busin	b. Kind of Business/Industry			
4	vithin	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		OO NOT use retired	•						
N T	iled v Hygie thar t		11 17. Father's Name (First, Middle, Last,		Car E	Electroni	LCS 18. Mother's Name	e (First Middle A	Self Emp	oloyed			
	od of	Be.	Milton Harold Pov						ŕ				
_	hould Me Id	은	19a, Informant's Name/Relationship (		19b. Mailine	n Address (Street)	and Number or Run	Marian (		te Zin Code)			
	ith ar ith ar 27 is trau		Annette Powell,				ad, Green		201.12	20770			
ָט פֿ	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatil and Mental Hygiene. Important: If time 27 Is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic svant. It is Medical Examinate out the indiffed at once.		20a. Method of Disposition	20b. Pl	ace of Dispos	sition (Name of patory or other place			20c. Location - Cit				
2	ages ent of nt: If i		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation /5 ☐ Other (Specif	Hemovai from State	-	n Cremator		3/2005 /	lexandri	la, Virginia			
	mit. J sartm sortar injui		21. Signalure of Juneral Syrvic > 1/ce				ss of Facility Gas						
בֿ	permi Depar Impor any ir	10.0	+aloute (1	1 aug	4.								
H			4739 Baltimore Avenue, Hyattsville, Maryland  23a. Parl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between										
	Pnysician :		Immediate Cause (Final disease or condition	I N No Po	100	Faller	2			Onset and Death			
	/Medical		resulting in death)	Due to (or as a consequ	ience of):		^ \	\	1				
	Examiner	iner	Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  Consequence of the consequence of the cause (Disease or injury that initiated events):  Due to (or as a consequence of):										
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	xecuted and II-transit	xamin	Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):										
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5	cate t	dical		d	· · · · · · · · · · · · · · · · · · ·								
<	ding se as	Physician/Medl	IF FEMALE:	23c. If yes, outcome of pregnar	ncv				23d. Date of	f dollaro .			
2	atten for u	cian	23b. Was decedent pregnant in the past 12 months?	months?  1 Live birth 2 Fetal death 3 Ectopic pregnancy						Day Year			
5	the d y the iched	ıysi	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□ Unknown									
L	The law requires that the death certificate be e ste has been signed by the attending physician page 2 should be detached for use as the buria	by Pt								co use contribute to the cause of death?			
3	quires n sign ald be	d b	Donates Co	Devotes Mclides typeraters or						2 No 3 Probably 4 Unknown			
3	s bee	Completed		*				24a. Was ar		e autopsy findings available			
	The Ister to had age 2	E O						autopsy perform	ned? deat	r to completion of cause of th? Yes 2 ☐ No			
9	sician: The law certificate has b irector, page 2 s	O	25. Was case referred to medical				26. Place of Deat						
>	ding Physician: The n. After this certificate h. funeral director, page	To B	examiner? 1   Yes 2   Nursing Home 5   Residence						nce 6 Other (	Specify)			
=	ding Phys The After this funeral di												
2	andii eath. or: A the fu	catio	1  Acident investigation M 1 Yes 2 No										
Ž	l or Attane after deatl Diractor: In by the	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  City or Town, Street, factory, office building, etc. (Specify)  286. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						eet and Number o , State)	t and Number or Rural Route Number, tate)			
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	To the Hospital or Attending Physicien: within 24 hours after death. To the Funaral Director: After this certifica completely filled in by the funeral director.	edical	29a. Certifier 1 Certifying Pt (Check only 2 Medical Exar	nysician: To the best of my knowniner: On the basis of examination	vledge, death ion and/or inv	occurred at the tin estigation, in my o	ne, date and place, pinion, death occuri	and due to the ca red at the time, da	use(s) and manne ite and place, and	er as stated. due to the cause(s)			
		Mec							d. Date signed (N	. Date signed (Month, Day, Year)			
	⊬ ≯ ∓ 8		1 ( Dall to	No.		22	5079		4/27/00				
0	1		30. Name and address of person who	completed cause of death (Item	23a) (Type F	Print) *		-					
1	(9)	1	Don El. Yalono.	off on she	4 Ex	e VILus s	P1. = 5	05, 10	rpon!	no 2070%			
	Sta	ite	31. Date filed (Month, Day, Year)	3 Registrar's Signat	ure	٠. قد							
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Registrar DHMH 17 Rev 1/2001

			1 - For State Ragistrar	State of N	Maryland		artmen rtificate					giene Rag. No.	UUU	)	161	79
	Physici	an	1. Decedent's Name (First, Middle, L				<u> </u>		•		2. Date of De Month	Day		əar	3. Time of	Death
	/Medic	al	Michael Leahy F		-1		45 65			- ( D 1)	April		2005 County of 1	Danib.	5:00	a M
	Examin	er	4a. Fecility Name (If not institution, garanteed Homewood Retire					deri	Location o	or Death			Frede		l-	
	Funeral				Age (In yrs. la:	st birthday)	If Under	1 Year	If Under		8. Date of Bir	th.			lace (State o	or Foreign
	Director		577-14-5610	1 ♣M 2 ☐ F	<b>8</b> 8	Yrs.	Months	Days	Hours	Min.	(Month, Da Aug. 14				ingto	
	and *		Usual Residence of Decedent  10a. State 10b. County		10c. City.	Town or Lo	cation							1	0d. Inside C	ity Limits
	Maryli f sho	lor	Maryland F	rederick		Fr	ederi	ck							1 🗌 Yes	2 🔯 No
	r 28a	Irec	10e. Street and Number 10f. Zip Code									10g. Cit	izen of Wha	it Coun	itry?	
	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. and Mental Hygiene is marked other than "natural", or Itema 23s or 28s-f show aumatic event, the Medical Examinar must be notified at	ai D	7407 Willow Ro	ad				2170	2				USA			
36		by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  1 □ Never Married 2 □ Married  1 □ Yes 2 ☒ No   If Yes, Give   Year or Dates:					Was Decedent of Hispanic Origin? (Specify Yes or No- It Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 ☐ Yes 2 ☑ No Specify:				-	14. Race - American Indian, Black, White, etc.  Specify: White			
5-0036	2 hou	ted	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working) life. DO NOT use retired)						16b. Kind of Business/Industry							
2121	ithin 7	Completed	Elementary/Secondary (0-12)	College (1-4d	or 5+)						Darcaa			of Engraving		
N	filed w Hygier other th	Cor	17. Father's Name (First, Middle, Las	5+		Mana	ageme	nt A			(First, Middle		Prin	ting	<u> </u>	
	d be findal h	Be c	Walter I. Plant								Leahy	Malogn	Sumamo			
aryland	should be tind Mental I marked o	2	19a. Informant's Name/Relationship	(Type, Print)	- 1	19b. Mailir	ng Address	(Street a			I Route Numb	er, City o	r Town, Sta	te, Zip	Code)	
ž	and 2 alth a 127 ls		James O. Plant/	Son		940	4 Car	mich	ael C	Court	, Fred	eric	k, MD	21	701	
altimore,	Fiten 12		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	☐Removal from Sta	l cor	ce of Dispo	sition (Nan matory or o	ne of ther plac	θ)	May	ate 2.	20c. Lo	ocation - City	y or To	wn, State	
Ĕ	Pag ment tant: jury c		`4 ☐ Donation 5 ☐ Other (Spec	ify)		Olive			ry	20	05		ingto		DC	
Ball	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury of ether traumatic evenes.		21. Signature of Funeral Service Lice			50	00 Un	iver	sity	Blvd	Funera , W, S	ilve	me Ind r Spr	ing,	,MD 20	901
1	Anysician /Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, effock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and Death										ween			
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ĕ.	death e atter	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \( \triangle							23d. Date of delivery Month D				Year		
P.O.	res that the de igned by the a be detached t	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did t	23e. Did tobacco use contribute to the ca			e cause of c	death?		
rds	w requires been sign should be									1 🔼 '	1 Nes 2 No 3 Probably 4 Unkno				Jnknown	
Division of Vital Records,	e la has je 2	Completed									24a. Was autor perfo	SV	24b. Wer prior deat	h?	psy findings apletion of c	available ause of
ta		Bec	25. Was case referred to medical 26. Place of Death (Ch.								<del> </del>					
<u>&gt;</u>	sis di	2	1 Tyes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home						me 5日Residence 6夏Other(Specify)Assisted				ted			
n C	Jing Ph J. After th funeral	ion:	27. Manner of Death  1 Accident  3 Suicide  Could not be determined.					Work?			28d. Describe how injury occurred Living					
ISIC	Attend death ctor: y the	ficat						M 1 Tyes 2 No			8f. Location (Street and Number or Rural Route Number,					
2	al or / s after al Dire	Certification:	4 Homicide determined building, etc. (Specify)						City or Town, State)							
	To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	edical (	29a. Certifier  (Check only one)  1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										5)			
	To the within To the comp	Me	29b. Signature and title of certifier	()	11.		29c	. License	number	20			te signed (N			
	5		/ AMA	1 ×//	1m	14	3)		D164	28 		Apri	il 27,	20	105	
	="		30. Name and address of person who completed cause of death (Item 230) (Type, Print)  Casper E. Cline, M.D. 300 West 9th Street, Frederick, MD 21701													
	Sta	te		2. Regi	strar's Signatu	re /	LII STI	Leet	, rre	uerı	UK, MD	Z1/(	ıΤ			
	Registr		31. Date filed (Month, Day, Year) APR 2 8 20	05 Blooms	strar's Signatu	Span										

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PLANT, MICHAEL

			State of Maryland / Department of Hea		-	•						
			1- For State State State of Walfyland / Department of Hea		Reg. N	2003	6 180					
	9		Decedent's Name (First, Middle, Last)		ate of Death	av. Voor	3. Time of Death					
	Physicia /Medic		M. Virginia Rosenbaum		5 0	4 05	17:20PM					
	Examin	er	4a. Fecility Name (If not institution, give street and number)  4b. City, Town, or Loc  City Old	ation of Death	4	c. County of Death	nu					
	E		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If U	Under 24 Hrs. 8 Da	ate of Birth	Allega	ana (State or Foreign					
	Funeral Director		212-18-1858 1 M 2 F 83 Yrs. Months Days Ho	ours Min. Se	ate of Birth fonth, Day, Year pt 3,1	921 Viro	ace (Slate or Foreign try) [inia					
	pu .		Usual Residence of Decedent									
	laryla shov	ō.	10a. State   10b. County   10c. City, Town or Location   Maryland Garrett   Frostburg			10	0d. Inside City Limits 1 ☐ Yes 2 ☑ No					
	28a-	rect	10e. Street and Number 10f. Zip Code		10g C	itizen of What Coun						
,	filed within 72 hours after death with the Maryland Hygiene. that then 'natural', or Items 23e or 28e-f show with Ite Micalcal Examitment count be mailfied at	Funeral Director	2245 Pocahontas Road 21532			USA						
	ams 2	ner	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispar Armed Forces? 13. Was Decedent of Hispar If Yes, specify Cuban, M	nic Origin? (Specify Y	es or No-	14. Race - America Black, White, 6						
36	s afte		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give 1 ☐ Yes 2 ☑ No Sp	pecify:	, 5.5.,		hite					
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7	7 nin 72 nin na	Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired)	g most of working	100.1	Talla of Dasillessyllia	ustry					
2	ed with	Com	12 2 Surveyor		Cou	inty Gov	ernment					
gu	be file	Be	- 1 - 1	Mother's Name (First								
Maryland	hould d Mer marke matic	2	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and N	Mildred H			0-4-1					
<u>⊠</u>	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Hygiene 27 is marked of the file in a Maryland Examiner count for multipled at once.		Eva Burt-Granddaughter 20803 W. Eucl									
č,	of Hea itam othe		20a. Method of Disposition 20b. Place of Disposition (Name of	Date	20c. L	ocation - City or Tox						
<u>E</u>	Page nent c ant: If ury or		1 ☑ Burial 2 □ Cremation 3 □ Removal from State  '4 □ Donation 5 □ Other (Specify)  **Cemetery, crematory or other place)  St. Joseph Cemete	27,2005	Joh	nstown,	PA					
Baltimore,	permit. Departn Imports eny inju		21. Souture of Funeral Service Licensee 22. Name and Address of Hafer Fros	Facility st Mansic								
	Pnysician /Medical Examiner		21. Solution of Funeral Service Licensee  22. Name and Address of Facility Hafer Frost Mansion Funeral Home  58 Frost Ave., Frostburg, MD 21522  23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,									
			23a. Part 1. Enter the disease or complications that caused his death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final Death Onset and Death Dea									
T			disease or condition resulting in death)									
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60,	ate be executed hysician and the burial-transit	cal Examiner	Due to (or as a consequence of):									
	ficate g phys is the		d									
Вох	Attanding Physician: The law requires that the death certifica riceath.  **roteath.** After this certificate has been signed by the attending phe to the funeral director, page 2 should be detached for use as the funeral director.	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of deliver	у					
Ö.	death ne atte	sicla	in the past 12 months?  1  Yes 2			Month I	Day Year					
P.O.	d by the	Phy	3 Olivilowii		0. 0.4.1							
ds,	signer b ed d	Completed by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in	Part I. 2	3e. Did tobacco 1 ☐ Yes 2	use contribute to the	bly 4 Unknown					
Sor	w require been signature should b		Thromboembolic Disease Protein S Deficiency	-								
Records,	he lav e has age 2	dmc	Trasteen 3 reflecting		4a. Was an autopsy performed?	prior to com death?	sy findings available pletion of cause of					
ta	an: T tificat tor. pa	Φ	25. Was case referred to medical 26	Place of Death Che	☐ Yes 2 XX No ck ant one	o 1 ☐ Yes	2 Se No					
<u>_</u>	nysici	To B	examiner?	□ Nursing Home 5		6 ☐Other (Specify)						
Division of Vital	ing Pt viter th		27. Manner of Death 1 ☑Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? 28c. Injury at Injury		escribe how inju							
Sio	tandii Jeath. tor: A the fu	catl	2 Accident investigation M 1 Yes 2 No 3 Suicide 6 Could not be									
É	in Street	Certification;	4 Homicide determined determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	Zar. Lo	ity or Town, Stat	nd Number or Rural e)	Houte Number,					
~	spita hours maral fillec		29a. Certifier  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	To the Hospital or Attanding Physician: The law within 24 hours after death. To the Funaral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	with To t	Σ	29b. Signature and title of certifier  H. Chotem  D 5-85			ate signed (Month, D						
				853		15/05						
	12		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  IHABIB A CHOTANI 131 PENNSYLVANIA A	IVE, CUA	MBERLA.	ND, MO	21502					
	Sta	te	31. Date filed (Month, Pay, Year) MAY 12, 2005 Registrar's Signature									
	Registr		MAT 1 % 2005 States A Sports									

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Year Doras A. Robinson рм /Medical April 2005 30 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Sligo Creek Nursing and Rehab Takoma If Under 1 Year Montgomery 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) July 23,1931 **Funeral**  Birthplace (State or Foreign Country) Days 1 ☐ M 21X F Months Hours Director 577-04-7387 Panama Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or items 23a or 28a-f ahow 10a. State 10b. County 10c. City, Town or Location ral', or items 23a or 28a-f ahow Examiner nust be notified at 10d. Inside City Limits Director TX Yes 2 No Md. Montgomery Takoma Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 7525 Carroll Ave 20912 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 XWidowed 4 Divorced Specify: Black other traumatic event, If a Mcdical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th <u>Beautician</u> Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jonathan Williams Enid Sobers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7520 Maple Ave #614 Takoma Pk.Md 20912 Rolando S. Robinson(Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages l Department of H Important; If ite any injury or ot once. 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Ceme May 4,05 4 ☐ Donation 5 ☐ Other (Specify) Suitland Md. 21. Signatural f Funeral Serice Licensee 22. Name and Address of Facility Tyrone J. Young 719 Kennedy St. NW 20011 23a. Part1. F er the disease, or complications the shock of heart failure. List or two ne cause aused the death Approximate Interval Between Onset and Death not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Jause (Final disease of condition PULMONARY APLAEST Physician /Medical resulting in death) THEROSLIERANC CAMPIONSCHAR DISCASE **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) The law requires that the death certificate be executed use as the burial-transit resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. 1 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

- RECUMENT PNEVMON A, 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 21 No Completed 3 Probably 4 □Unknown 1 TYes TRESTOMY TUBE FUEDS, MALNUTRITION. 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? PREJUNESONE: LACKUM, COMFORT CARE 1□ Yes P□No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: Nursing Home 5 Residence 6 Other (Specify) 2 Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Natural 5 Pending investigation 2 Accident Director; 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours at To the Funeral D completely filled i Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D53367 4/28/05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JUINE: 202, GAITHENSBURG, MD: 20878 10810 DARMETOWN ROAP. SHYANKUMMAR. RAJAN 2. Registrar's Signature 31. Date filed (Month, Day, Year) State APR 2 9 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year 27, 2005 4c. County of Death /Medical James L. Read 5:05A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Casey House
5. Social Security Number Montgomery

9. Birthplace (State or Foreign Country) Rockville
If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1**X** M 2□ F Yrs. **Director** 220-26-9946 1926 Maryland 78 June 19, Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location nd 2 should be filed within 72 hours after death with the Marylan Ith and Mental Hygiene. 27 is marked other than "naturel", or items 23a or 28e-f show treumatic event. I'm Medical Examination mat be notified at 10d. Inside City Limits Director 1 Yes 2 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 13917 Overton Ln 20904 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 → Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced WWII White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Physician Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ဥ Foster Read <u>Evelyn Pfeiffer</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh
Department of Health and
Importent: If item 27 is m
any injury or other treum Shirley Read/Wife 13917 Overton Ln. Silver Spring, MD 20904 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐XBurial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐Donation 5 ☐ Other (Specify) Frostburg Memorial Park May 2, 2005 Frostburg, MD 22. Name and Address of Facility Hines-Rinaldi Funeral Home 21. Signature of Funeral Service License alan Demas O 11800 New Hampshire Ave, Silver Spring, MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Brain Tumor disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (218-25-25 in jus) Examiner Due to (or as a consequence of) ng physician and as the burial-transit law requires that the death certificate be executed Cause (Discuss or i that initiated events resulting in death) Last Due to (or as a consequence of): 68760. Physiclan/Medical P.O. Box IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. cate has been signed page 2 should be de 23e. Did tobacco use contribute to the cause of death? Records, by Be Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗆 No 1 Yes 1 ☐ Yes Vital Physicien: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Cther: 4 Nursing Home 5 Residence 6 Hother (Specify) 1 ☐ Yes 2X No Hospice Certification: To of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Hospital or Attending Injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one)

30

29b. Signatui

and title of ce

Joseph Kaplan, MD

APR 28 2005

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001 2. Registrar's Signature

29c. License number

18111 Prince Philip Dr, #327, Olney, MD 20832

D35635

29d. Date signed (Month, Day, Year)

April 27, 2005

		-	For State Registrar	State of Man	yland		rtment of H				iene og. No. 005	16183
	Physicia /Medic	an	1. Decedent's Name (First, Middle, La Gay	drian	Roc	lgers			Apri		Day Year 24 2005	3. Time of Death 10:15 p M
	Examin		4a. Facility Name (If not institution, gi	re street and number)			4b. City, Town, or Lothi		of Death		4c. County of Dea	
	Funeral Director		725-07-9114	Sex 7. Age (// 1 M 2 <b>X</b> F <b>7</b> 1	-	t birthday) Yrs.	If Under 1 Year Months Days		24 Hrs. 8. Date (Mor. July	of Birth oth, Day,	9. Bir	thplace (State or Foreign ountry)
	land ow		Usual Residence of Decedent  10a. State 10b. County	10	0c. City,	Town or Lo	cation					10d. Inside City Limits
	a Mary	Director	MD Anne Ar	rundel			Lothi	ian				1 ☐ Yes 2 No
	with th		10e. Street and Number				10f. Zip Code 20711	1		1	0g. Citizen of What C	ountry?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If item 27 is marked other then "naturel", or Items 23e or 28e-f show importent: If item 27 is marked other then "naturel", or Items 23e or 28e-f show principly or other treumetic event, Ire Modeal Exartiner must be inclifted at ance.	by Funeral	246 Bayard Road  11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Decedent Eve Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	er in U.S.	1	Was Decedent of Hi f Yes, specify Cuba I ☐ Yes 2X No	ispanic Or	n, Puerto Rican, e	s or No- etc.)	14. Race - Am Black, Whi	
21215-0036	nin 72 hour n "naturel	Completed t	15. Decedent's E (Specify only highest g.	ducation		(Give	lent's Usual Occupa kind of work done of OO NOT use retired	during mos	st of working		16b. Kind of Business	
	filed with Hygiene other the ent, tre		12			Postm	aster	18 Moth	er's Name (First,		US Postal	Service
Maryland	ould ba fil Mental H arkad ott etic even	To Be	17. Father's Name (First, Middle, Las					Gay	_		Duke	
lary	2 should I and Men Is marka eumetic	-	19a. Informant's Name/Relationship	(Type, Print)			-	and Numb	er or Rural Route	Number	r, City or Town, State,	Zip Code)
	Health tem 27 tothar tre		Gwen A. O'Brien, 20a. Method of Disposition	daughter			ayard Rd. sition (Name of natory or other place		othian, M	-	20711 20c. Location - City o	r Town, State
Baltimore,	permit. Pagas. Department of H Importent: If ite eny injury or ot	١.	1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec	I Hamovai nom State I			natory or other plac ial Garde	I	04-28-20	005	Dunkirk, I	MD
<b>3alti</b>	permit. Departm Importe eny inju		21. Signature of Funeral Service Lice			22	. Name and Addres	ss of Facili	ity			
	<u></u> <u> </u>	11.3	23a. Part1. Enter the disease, or co	nplications that caused th	ne death.						, Owings, I est.	Approximate
	Pnysician /Medical		shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)	a		1,100	east i	car	ncer			Interval Between Onset and Death
	Examiner		Sequentially list conditions.	b								
	tad nsit	niner	Sequentially list conditions, if any, leading to immediate cause (Disease or injury	Due to (or as a c	conseque	nce of):						
,09	death certificate be executad e attending physician and id for usa as the burial-transit	Ical Examin	that initiated events resulting in death) Last	c.  Due to (or as a c	conseque	nce of):						
68760	rtificate b ng physicas the b	ed	IF FEMALE:	0.								
.O. Box		Physiclan/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 [ 4 ☐ Pregnant at tin 9 ☐ Unknown	Fetal d	eath 3	Ectopic pregnancy Other (specify)	<u>'</u>			23d. Date of de Month	elivery Day Year
s, P	es tha gned be de	by	Part II. Other significant conditions	contributing to death but t	not result	ing in the u	nderlying cause giv	en in Part	1. 23	e. Did to	A	to the cause of death?  Probably 4 □Unknown
Record	<b>6 C 0</b>	Completed								a. Was a autops perform	sy prior to	autopsy findings available completion of cause of s 2 \sum No
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Oth	Or.	ce of Death (Chec			
of	ing After une	tion: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigat	28a. Date of Injury (Month, Day Y	2	R/Outpatier 28b. Time o Injury	f 28c. Injur	y at	28d. De	-	ence 6 □Other (Sp ow injury occurred	ecity)
Division	- E E	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		y - At horr (Specify)	ne, farm, str	reet, factory, office			ation (Say or Town	treet and Number or F n, State)	Rural Route Number,
	To the Hospitel or within 24 hours after To the Funerel Dir completely filled in	edical (	29a. Certifier 1 Certifying I (Check only one)	Physician: To the best of aminer: On the basis of each manner state	xaminatio	on and/or in	vestigation, in my o	pinion, de	eath occurred at th	e time, d	late and place, and du	ue to the cause(s)
)	To the within To the comp	Me	29b. Signature and title of certifier	o completed cause of dea Selonic 27 2005	10	)	29c. Licens	e number	38	2	29d. Date signed (Mor	nth, Day, Year)
	15		30 Name and address of person wh	o completed cause of dea	ath (Item 2	23a) (Type. WO	Print900	Bes	trate 1	2d.	Annapo	lis, Md.
		ate rar	31. Date filed (Month, Day, Year)	3 7 2005 Registr	s Signatu	ire &	Sperke	)	· · · · · · · · · · · · · · · · · · ·			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month April Year **Physician** Margaret Pazzetti Reber 24 2005 10:22 P.M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Calvert Memorial Hospital Prince Frederick Calvert 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1□M 2√2F 193-16-0116 Yrs. Director 84 1920 Pennsylvania Usual Residence of Decedent should be filed within 72 hours after death with the Maryland and Mental Hygiene.
marked other than "natural", or Iteme 23s or 28s-1 show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rthan "natural", or Iteme 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2X No Maryland Calvert Solomons Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 11750 Asbury Circle AL 103 20688 United States Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ★ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes X☐ No Specify: þ XXWidowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housewife Homemaker permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: if item 27 is marked othe any light yo other treumatic event 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Vincent J. Pazzetti, Jr. Miriam Albright 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Reber (Son) P. O. Box 131, Solomons, Maryland 20688 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 4/25/05 Alexandria, Virginia 22. Name and Address of Facility Rausch Funeral Home, P.A. 4405 21. Signature of Funeral Service Licenses Broomes Island Rd., Port Republic, MD 20676 23a. Part1. Enter the risease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** preumania /Medical Due to (or as a consequence of) Examiner Due to (or a la consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last Shock Due to (or as a consequence of) attending physician a for use as the burial-Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregg 3 Ectopic pregnancy Year in the past 12 mor Month Day Pregnant at time of death 5 Other (specify) the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate has autopsy perform 2 No 1 Yes or Attending Physician: Be 25. Was case referred to examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 2 1 Tyes 3∏ DOA this 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? of Death 28d. Describe how injury occurred Certification: Matural Natural After 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death the 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funerel C Hospite 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medicai (Check only one) 29d. Date signed (Month, Day, Year) Signature and title of certifier 29c. License number D0060120 AN MOW! MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hospital Rd. prince frederick, no 20678 Hagothmn 100 4. wael 31. Date filed (Month, Day, Year) 32. Registres Signature State 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician Betty B. Ratliff 25, 5:30 p<sup>M</sup> Apr. 2005 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Crownsville Fairfield Nursing Home Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer)
Jul. 17, 1924 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6 Sex 5. Social Security Number Days **Funeral** Hours Min. Months 1 M 2 TE 80 Yrs. MD 218-12-2707 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County rai, or items 23s or 28a-f show Examiner must be notified at 1 Yes 2 No Director Anne Arundel MD Crofton 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number with 1 21114 USA 2509 Dog Leg Drive Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give 11. Marital Status filed within 72 hours after 1 Never Married 2 ☐ Married White 1 ☐ Yes 2 XNo Baltimore, Maryland 21215-0036 Specify: Specify: þ 3 ☑ Widowed 4 ☐ Divorced Year or Dates: "natural" Completed 16b. Kind of Business/Industry the Medical 16a. Decedent's Usual Occupation 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) then College (1-4or 5+) Westinghouse Assembly Line Worker 12 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) th and Mental P 77 is marked of traumatic ever Pages 1 and 2 should be Marie Bennett John E. Green 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) at of Heam. at: If Item 27 if 2509 Dog Leg Drive, Crofton, MD Judy Pandolfino/Daughter May 2, 2005 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State MD Veterans Cemetery Crownsville, MD Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) permit. 21. Signature of Funeral Servine Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 23. and Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmedia : Cause (Final disease r condition resulting in death) Pnysician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Box 68760, nding physician Physician/Medical use as the IF FEMALE. 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No į 4□Pregnant at time of death 5 Other (specify) P.O. the it 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part II Division of Vital Records. þ pe 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Be Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? page 2 2 **3**00 1 ☐ Yes 2 No 1 TYAS or Attending Physician: funeral director. 25. Was case referred to medical 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient this 28c. Injury at Work? 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident the within 24 hours after deatl To the Funeral Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) in by t 4 Homicide pelli Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie who completed cause of death (Item 23a) (Type, Print) 30. Name and address of perso nnapola 1)a 100 CAA Month, Day, State 2 Registrar

		ite of Death	Reg. No.	005   6  86
Physician /Medical	1. Decedent's Name (First, Middle, Last)  Jordan Isabella Sansbury	4	2. Date of Death April 28 2005	3. Time of Death 1 23P M
Examiner	1430 Platteau Road St. 1	y, Town, or Location of Death Lecnard	Calv	
Funeral Director	5. Social Security Number 213–69–8252  G. Sex  1 M 2 F 7. Age (In yrs. last birthday) Months  Usual Residence of Decedent	er 1 Year If Under 24 Hrs. s Days Hours Min.	8. Date of Birth (Month, Day, Year) <b>January 7 2004</b>	Birthplace (State or Foreign Country)     Maryland
show at all	10a. State 10b. County 10c. City, Town or Location  Maryland Calvert St. Leonard			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
with the Manual a or 28a-1	10e. Street and Number 10f. 2	tip Code 0685		n of What Country?
altimore, Maryland 21215-0036  nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hyglene.  ortant: If Item 27 is marked other than "natural", or items 23s or 28s-f show injury or other traumatic svent, the Madical Examiner must be notified at 8.  To Be Completed by Funeral Director	1 1√2 Never Married 2 ☐ Married 1 ☐ Yes 2 1√2 No	edent of Hispanic Origin? (Spec ecify Cuban, Mexican, Puerto R 2 \( \frac{1}{2} \) \( \frac{1}{2} \) \( \frac{1}{2} \)	ican, etc.)	Race - American Indian, Black, White, etc. pecify: white
Maryland 21215-0036 at 2 should be filed within 72 hours aft th and Mental Hygiene. It's marked other than "natural", or traumatic svent, tre Medical Exami To Be Completed by F	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  n/n  16a. Decedent's Us (Give kind of w life. DO NOT  n/a	vork done during most of working	g 16b. Kind	of Business/Industry
yland 2 Juld be filed Mental Hygi arked other atic svent, I	17. Father's Name (First, Middle, Last)  Robert Sansbury	18. Mother's Name (	(First, Middle, Maiden Su	mame) Hall
Mary Id 2 shou Ith and M Ith and M Ith and Ith Ith and	19a. Informant's Name/Relationship ( <i>Type, Print</i> ) 19b. Mailing Address	ss (Street and Number or Rural, u Rd. St. Leonard,		own, State, Zip Code)
altimore, mit. Pages 1 ar partment of Hea portent: If Hem? y injury or other	20a. Method of Disposition  1 \[ \sum_{\text{Burial}} 2 \] \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	ame of Da	ite 20c. Locat	ion - City or Town, State  Maryland
Baltimor. permit. Pages Department of t Important: If ite any injury or of	21. Signature of Funeral Service Licensee  22. Name 2  23. Part1. Enter the disease, or complications that caused the death. Do not		ch Funeral Hom	
8760, sate be executed making by sician and the burial-transit the burial-transit dical Examiner	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	5		Inierval Between Onset and Death
Box 6 death certific death certific a tending p of for use as	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic 4 Pregnant at time of death 5 Other (s		23d	l. Date of delivery Month Day Year
	Part II. Other significant conditions contributing to death but not resulting in the underlying  Auctic Brain Tujury	cause given in Part I.	23e. Did tobacco use 1 ☐ Yes 2 ☑ N	contribute to the cause of death?
I Rec I Rec The law ate has b page 2 sl			24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No	24b. Were autopsy findings available prior to completion of cause of death?  1 ☐ Yes 2 ☑ No
Division of Vital  To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this cartifica completely filled in by the funeral director. Medical Certification; To Be C	25. Was case referred to medical examiner?  1 Yes 2 No  1 Inpatient 2 EP/Outpatient 3 Input investigation 3 Suicide 4 Homicide  Hospital: 1 Inpatient 2 EP/Outpatient 3 Input investigation 4 See. Place of Injury (Month, Day Year)  28a. Date of Injury (Month, Day Year)  28b. Time of Injury (Month, Day Year)  28b. Time of Injury M  28e. Place of Injury - At home, farm, street, factor building, etc. (Specify)	28c. Injury at Work? 1 Yes 2 No	e 5 Fesidence 6 C	
ne Hospital no 24 hours a ne Funeral bletely filled	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurre 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.	d at the time, date and place, and on, in my opinion, death occurred	nd due to the cause(s) and d at the time, date and pla	d manner as stated. ace, and due to the cause(s)
To the within To the comple	29b. Signature and title of certifier  5 5 5 6 41 M D	D0060505		igned (Month, Day, Year)
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Or MAN BIT SUCH 13b HOSPITAL IS  31. Date filed (Month, Day, Year)  APR 2 9 2005	CORC Prince	Frederic	k MU 20678

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1 Decedent's Name (First Middle Last) Day Month Year **Physician** 11:25 A April 28 2005 A. Ruth L. Sauder /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Cecil Chesapeake City 2936 Old Telegraph Road If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year)
July 13, 1 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 □ M 2 K F Yrs. 85 203-07-6268 1919 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 7 is marked other then "netural", or Items 23a or 28a-f show treumatic event. If a Mcdical Examinar must be notified at 1 ☐Yes 2 No Director MD Cecil Elkton 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21921 USA 395 Hutton Road death Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ऒ No If Yes, Give Year or Dates: 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. is 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: à White 3 □Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ann Kilheffer Isaac Lehever ဨ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 190 Maple Grove Rd., Hanover, PA 17331 Benjamin Sauder/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If iter
any injury or oth 5-2-2005 1 XBurial 2 Cremation 3 Removal from State Quarryville, PA Bethel Mennonite Cemetery ' 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility R.T. Foard Funeral Home, 318 George Street, Chesapeake City, MD 21. Signature of Funeral Service Licensee c/a ana 23a. Part . Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one calls on each light. Approximate Interval Between Onset and Death "Atheroschootie Heart Disease Immediate Cause (Final disease or condition resulting in death) anknown Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Dualto for as a consequence of) Examiner sate has been signed by the attending physician and page 2 should be detached for use as the buriat-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown Completed 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No After this certificate or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Gaughters Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 28d. Describe how injury occurred 27. Manner of Death 1 ☑Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 5 Pending investigation death, 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide within 24 hours a To the Funeral C the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 29c. License number /05 achders MD D0023322 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. S. Sachdev 118 N. Street, Elkton, MD 21921 31. Date filed (Month, Day, Year) Registrar's Signature State APR 2 9 2005 Registrar

		1 - For State Registrar	State of Maryland / I	Department of Health  Certificate of Death	7 F	leg. No. ZUUD	15188
Phy	sician	1. Decedent's Name (First, Middle, Last) Lerov	Smith	Jr	2. Date of Dea Month	Day Year	3. Time of Death
	ledical				April	24, 2005	2020 M
Exa	aminer	4e. Facility Name (If not institution, give s 6820 Kent Roa		4b. City, Town, or Location Sunderla		4c. County of Death	
		5. Social Security Number 6. Sex		nthday) If Under 1 Year If Under	er 24 Hrs. 8. Date of Birtl		plece (State or Foreign ntry)
Fune Direc			M 2□F 80	Yrs. Months Days Hours	Min. (Month, Day Mar. 4,	1925 Mary	niry) 71and
yland	100	10a. State 10b. County	10c. City, Tov	m or Location			10d. Inside City Limits 1 ☐ Yes ※☐ No
e Mar	cto	Maryland Calve	rt	Sunderland			
27273-5-UU36 4 within 72 hours after death with the Maryland piene. 7 than "natural", or fleme 23a or 28a-f show	Funeral Director	10e. Street and Number	3	10f. Zip Code		10g. Citizen of What Cou	ntry?
ath w	la la	6820 Kent Roa		20689	Princip? (Specify Vac or No.	USA 14. Race - Ameri	can Indian
er de	nue nu	11. Marital Status  1 □ Never Married 2 □ Married	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No	13. Was Decedent of Hispanic C If Yes, specify Cuban, Mexic	an, Puerto Rican, etc.)	Black, White,	
ad within 72 hours aft giene.	by F		If Yes, Give Year or Dates:	1 ☐ Yes 2 X No Specif	y:	Specify: B]	lack
hou stura	t, the Medical Exact Completed by	15. Decedent's Edu		Decedent's Usual Occupation		16b. Kind of Business/Ir	ndustry
nin 72	plet	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	Decedent's Usual Occupation (Give kind of work done during mo life. DO NOT use retired)	ost or working	0	
77 57 5	E E	4		Laborer		Construct	tion
12 should be filed h and Mental Hygid 7 is marked other	yent,	17. Father's Name (First, Middle, Last)	0 1 1		her's Name (First, Middle,		
should be nd Mental	To Be	Leroy	Smith		letha	Chase	
and 2 sho ealth and n 27 is m	other traumatic avent,  To Be C	19a. Informant's Name/Relationship (Ty Beverly Smith/I		p. Mailing Address <i>(Street and N</i> um 109 Barker Pla		r, City or Town, State, Zi , MD 20706	o Code)
permit. Pages 1 a Department of Hez Important: If Item	othe	20a. Method of Disposition		of Disposition (Name of ery, crematory or other place)	Date	20c. Location - City or T	own, State
Pages nent of int: If it	ry or	1 XBurial 2 Cremation 3 F 1 Donation 5 Other (Specify)	emoval from State	Edmonds UMC	4/30/05	Chesapeak	Bch., MD
permit. Pages Department of Important: If if	eny inju	21. Signature of Funeral Service Licens		22. Name and Address of Fac 1451 Dares	Beach Rd.	uneral Ho	
INDE:		23a. Pant1. Enter the disease, or compl	ications that caused the death. Do	Prince Fred	erick MD as cardiac or respiratory ar	20678 rest,	Approximate
1000		shock, or heart failure. List only or Immediate Cause (Final	ne cause on each line.	1. ( : 0	1		Interval Between Onset and Death
Physic Med/		disease or condition resulting in death)	Due to (or as a consequence		arction		
Exami			Carana	an Artera	D1580	10	
1.0	je je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	of):	)		
be executed sician and	ial-transit  Examiner	Cause (Disease or injury that initiated events	>				
be executed ician and	Exa Ex		Due to (or as a consequence	of):			
ate be			d				
The law requires that the death certificate are has been signed by the attending physi	letached for use as the Physician/Medic	IF FEMALE:					
ath ce	or us	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal deat			23d. Date of delive Month	very Day Year
e des	hed fo	1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at time of death 9□Unknown	5 Other (specify)			
hat the	detached y Physic		otributing to death but not resulting	in the underlying cause given in Par	rt I. 23e. Did to	bacco use contribute to	the cause of death?
ires tha	م م		ggg	, , , , , , , , , , , , , , , , , , ,		res 2□No 3□Pro	bably 4 Dtinknown
w require been si	page 2 should				24a. Was	an 24h Wara aut	oney findings available
e law	3 8 2 E				autor	rmed? death?	opsy findings available ompletion of cause of
ician: Th	Com				1 ☐ Yes	2 No 1 Yes	2 No
Physician: r this certific	director.	examiner?	Hospital:	Other	ice of Death (Check only of Nursing Home 5 Resident		(6.)
Phys	ral dir			Outpatient 3 DOA 4 Time of 28c. Injury at Work?		now injury occurred	ny)
ding P h.	fune for	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury Work?  M 1 ☐ Yes 2	□No		
or Attending Physician: The law requires talter death. Director: After this certificate has been signs	by the	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, office	28f. Location (S City or Tox	Street and Number or Rui	ral Route Number,
tal or s afte	ed in by the funera	4   Homicide	building, etc. (Speciny)		O. A. J. C.	Stato)	
To the Hospital or Attend within 24 hours after death To the Funeral Director:	completely filled in by the funeral Medical Certification: 1			ge, death occurred at the time, date and/or investigation, in my opinion, d			
To the I	Med	29b. Signature and title of certifier		29c. License numbe	er n	29d. Date signed (Month	, Day, Year)
<b>⊢</b> ≱ ⊢	Ö	7) Ca	111111	1 10002	21	Ulzalan	5
		30. Name and address overson who c	ompleted cause of death (Item 23a	) (Type, Print)	eny	10,61200	5 20639
5		Raymon A	Noble WD	32 Cox R	d Hunti	4 wester	1) 50026
70	State	THE STATE OF THE S	32 Registrates Signature	14			
Re	egistrar		( LUUJ Blokers	II. Dogate 1			

ORIGINAL

amend Item#29d, perDVR, 5/12/05 IT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 19. **Physician** 2005 James Sutton 7:22 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Clinton Prince George's | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. Birthplace (State or F Country) | Norths | Days | Hours | Min. | Sept. 19,1942 | Maryland 7. Age (In yrs. last birthday) 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** 220-42-2943 1 □XM 2 □ F 62 Yrs Director Usual Residence of Decedent with the Maryland 10b. CountyPrince 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Exertainer Pust be notified at Suitland 1 ☐ Yes 2 No Director Maryland George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 5916 Robin Lane 20746 USA permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural". ... 10-10.000. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify. Specify: Black þ 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Laborer Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Sutton Loretta Smith ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Yolanda Sutton/Daughter 5 Temple Court NW Washington, D.C. 20001 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State place) 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Eastern UMC Cem. 4/26/2005 Lusby, 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Sewell121. Signature of Funeral Service Licensee Funeral Home Prince Fred.,MD20678 Blacky 4. 1451 Dares Beach Rd. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final shock Physician Septic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Street coccal bacteremia Porta-cath Sequentially list conditions, I any, leading to in healate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner inding physician and use as the burial-transit The taw requires that the death certificate be executed hiver Colon Cance resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical attending IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy JO in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) P.O. | the a 9☐ Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 99 cate has been sig 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? certificate 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 WNatural 5 Pending Injury death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Ś 4 🗌 Homicide hours after 24 hours a 29a. Certifier 🛮 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0062167 MO 05

State Registrar 7503 Surratts Rd.

Clinton, MD 20735

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

2005▶

32. Registra Signature

Hossin Akhondi,

31. Date filed (Month, Day, Yea

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year SAGE CATHERINE STYRON MARCH 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HEALTHCARE BALTIMORE AGNES If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number Funeral 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) 1□M 2XF Director AM Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic svent, the Medical Example must be notified at MD. Completed by Funeral Director BALTIMORE 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 6620 ane items 23a Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 No Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) INFANT IN FANT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) h and Mental H Be Pages 1 and 2 should be NOT SHERRIE KNOWN HOLLE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Sherrie Holley 6620 Vincent MO. 21215 BALTIMORE 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ō <u>=</u> 1 Burial 2 Cremation 3 Removal from State ö Department of Importent: If any injury or once. NEW CATHEDRAL CEMERCY BALTIMORE `4 ☐ Donation 5 ☐ Other (Specify) 2005 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HOSPITAL ST. AGNES 900 CA7 BALTIMORE MARYland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) a. Suspected sepsis Priysician days /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, severe short gut syndrome secondary to recording entercedits 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown gestational ag 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an by Achepulmmany dis Isia, acute regnal autopsy performed? 25. Was case referred to medical examiner? aystunction 2 No 2 No 1 Tyes 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☐ No 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation М 1 ☐ Yes 2 ☐ No death after death 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 \ Homicide within 24 hours a To the Funerel C 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

Baltimor

30. Name and address of the son who completed cause of death (Item 23a) (Type, Print)

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		1	For State Registrar	ate of Ma	-	artment of rtificate of		nd Mental Hyg	giene () (	5 16191
	Dharist		Decedent's Name (First, Middle, Last)	····	-			2. Date of Dea	Dav	3. Time of Death
	Physicia /Medic	al	Dirk		Vandenbe			May 4,		7:10 A <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, give stree	t and number)			or Location of	Death	4c. County	
			Memorial Hospital  5. Social Security Number 6. Sex	7 400	(In yrs. last birthday)	Cumbe If Under 1 Yea		Hrs. 8 Date of Birt		egany  9. Birthplace (State or Foreign
ш	Funeral Director		215-26-6364 XIM			Months Day		Min. 8. Date of Birt Sep 16	1914	Holland
	D		Usual Residence of Decedent							40.1.1.1.0.0.1.0
	72 hours affer death with fhe Maryland neturel; or Iteme 23e or 28e-f show Jisal Ezzvither rust be notified at	2	MD Allegany		10c. City, Town or Lo Cresa					10d. Inside City Limits
	the M	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citizen of V	
	3e or	Ϊ́	14910 Grant Street				21502		US	
	death me 2	nera	11 Marital Status 12. V	Vas Decedent E Armed Forces?	ver in U.S. 13.	Was Decedent of	Hispanic Origi	n? (Specify Yes or No Puerto Rican, etc.)	14. Rac	e - American Indian, ck, White, etc.
9	affer or Ite	F	1 Never Married 2 Married	Yes 2 No	,	1 □ Yes 🎦 N		dorto i licari, cic.,		white
21215-0036	hours urel',	d by	Widowed 4 Divorced	Year or Dates:		dent's Usual Occ	unation			wille usiness/Industry
7	in 72	Completed	15. Decedent's Education (Specify only highest grade continuous)	mpleted)	(Give	kind of work don DO NOT use retii	e during most of	of working	100. Killy of Bu	asiness/industry
212	filed within Hygiene. Ither than "	Шо	Elementary/Secondary (0-12)	College (1-4or 54	aborer				Tire Con	npany
Maryland	d tait	Be	17. Father's Name (First, Middle, Last)					s Name <i>(First, Middl</i> e, je (Kuizeno		
ryla	shoutd ind Men s marke umatic	2	Jan Vandenberg  19a. Informant's Name/Relationship (Type, 1	Print)	19b Mailir	ng Address (Street		or Rural Route Number		
	and 2 s ealth an n 27 ls i		Steven Vandenberg	son		Seymour		Cumb		MD 21502
ē,	ges 1 and 3 f of Health if item 27 or other tr	1	20a. Method of Disposition		20b. Place of Dispo	sition (Name of natory or other p	lace)	Date	20c. Location -	City or Town, State
Ē	Pages nenf of I ant: If ite		1 X Burial 2 ☐ Cremation 3 ☐ Remo '4 ☐ Donation 5 ☐ Other (Specify)	val from State	Sunset Mem	orial Park		5/9/2005	Cumbe	rland MD
Baltimore,	permit. Page Department Importent: If any injury or once.		21. Signature of Funeral Service Licensee	M	11 22			l Home, PA nue: Cumberl	and. MD 2	21502
			23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one complications are complicated to the complete shock of the complete	ons that caused	the death. Do not ent					Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	End-S	stage Ki	daev	Diser	->e		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):	(				
		-e	S - uentially list conditions, b if any, leading to immediate	Due to (or as a	consequence of).					
V	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.							
0	an an	Exa	resulting in death) Last	Due to (or as a	consequence of):					
8760,	requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transit	dicai	d							
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Box	atten	Physician/Me	in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at t	2 ☐ Fetal death 3 ☐	Ectopic pregnar Other (specify)	псу		Mo	te of delivery nth Day Year
0	that the de ed by the detached	hysi		9□ Unknown						
s, P.	signed by det		Part II. Other significant conditions contrib	uting to death bu	t not resulting in the u	nderlying cause	given in Part I.			ribute to the cause of death?
ord	w require been sig should b	ted						10`	res 2 €No	3 ☐ Probably 4 ☐ Unknown
Vital Record	aw as b	Completed by						24a. Was autor	ysy	Were autopsy findings available prior to completion of cause of
<u>~</u>	: The cate h	Con						1 ☐ Yes		death? 1 Yes 2 No
Vita	Physicien: this certific ral director,	Be	25. Was case referred to medical examiner?	ital:			)than	of Death (Check only o		
o	Phys r this ral dii	To To	T Tes 2 No	1 @ Inpatier	The state of the s	IL SU DOA	4 🗆 14013	sing Home 5 Resident	tence 6 ∐Oth now injury occurr	
	Attending ir death. ector: After by the fune	tion	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	8a. Date of Injury (Month, Day	Year) Injury	W	ìork? □Yes 2□N	0		
Division	Attendi	ifice	a Could not be	8e. Place of Inju	ry - At home, farm, sti	reet, factory, offic	е	28f. Location (S City or Tov		er or Rural Route Number,
Ö	s after et Direct	Certification:	4 Tromedo	Daliding, etc	. (Opecny)					
	To the Hospital or Attending Physicien: The within 24 hours after death.  To the Funeref Director: After this certificate his completely filled in by the funeral director, page	edicai	29a. Certifier (Check only one)  1 Certifying Physicia 2 Medicel Examiner:		examination and/or in			occurred at the time,	date and place,	and due to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	1			nse number		_	d (Month, Day, Year)
•	,		1 / Jamera				D14865		May S	, 2005
	15		30. Name and address of person who compl Dr. R. Barrera, Mem.				do. Ci	umherland	MD 215	02
	Sta	ate	31. Date filed (Month, Day, Year)		r's Signature	TTCUT DI	.46., 00	ocracitus	413	
	Registi	-4	MAY 1 2 2005	El muer	11 for	2				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death -1. Decedent's Name (First, Middle, Last) Day Month 20 AM **Physician STRAKA** VALONE 26 VIOLA 2005 /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ROCKVILLE MONTGOMERY HEBREW HOME If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1 □ M 2**X**□ F Yrs. 058-01-1037 1909 **NEW YORK** Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow other traumatic event, the Madical Examinar must be nutilized at 1 ¥ Yes 2 □ No Director MD. MONTGOMERY ROCKVILLE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ö U.S.A. MONTROSE RD. 20852 or items 23a 6121 Completed by Funeral filed within 72 hours after death 14. Race - American Indian, Black, White, etc. 12. Was Decadent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: 3 ▼Widowed 4 □ Divorced WHITE "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: if Itam 27 ts marked other than Elementary/Secondary (0-12) College (1-4or 5+) 10 HOUSEWIFE HOME 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be **JACOBY CECILIA** HOROWITZ TSADORE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TEREZIE S. BOHRER/DAUGHTER 16304 BAWTRY CT., BOWIE, MD. 20715 20b. Place of Disposition (Name of cemetery, crematory or other place) Date ₹ 1 ☐ Burial 2 ▼Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 50 CHAMBERS CREMATORY 4-27-2005 RIVERDALE, MD. 22. Name and Address of Facility
CHAMBERS FUNERAL HOME & CREMATORIUM, P.A.
5801 CLEVELAND AVE., RIVERDALE, MD. 20737 21. Signature of Funeral Service Licensee M00091 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** atherosclen/1c Cardiovacala /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate the sequence of the Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of). IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day ğ in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) 1 Yes 2 No o. page 2 should be detached 9 Unknown ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 3 Probably 4 Winknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2E No Viital or Attending Physician: fineral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient Other: Certification: To 1 ☐ Yes 2 ☑ No 4 rsing Home 5 Residence 6 Other (Specify) 3 DOA o 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending 1 Tyes 2 □ No investigation 2 Accident he Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours after To the Funeral Dire Hospital 🗠 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) trong D: 44907 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Road RICKVILLE mo \$2. Registrar's Signature 31. Date filed (Month, Day, Year) State 28 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Day 2005 Year April 27, **Physician** 4:50 A Phyllis Joyce Van Camp /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery 12509 Kuhl Road Silver Spring If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth Dec. 8, 1940 9. Birthplace (State or Foreign 5 Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Washington, DC 220-38-4192 1 ☐ M 2 🛱 F 64 Yrs Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 28a-f show treumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō 20902 12509 Kuhl Road United States items 23a death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. s 1 and 2 should be filed within 72 hours after f Health and Mental Hygiene. Armed Forces? 1 □ Yes 2√ No If Yes, Give 1 Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: þ white 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Medicine 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Martin Littman Eva Smith 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Husband William Jeremiah Van Camp 12509 Kuhl Road, Silver Spring, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Himportant: If ite any Injury or of once. 1 ☐ Burial 2 ☐ Cremation 3☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) National Memorial Park 04/29/05 Falls Church, VA 21. Signature of Funeral Service Licensee Porchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC 20012 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) FAILURE Examiner STAGE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury to (or as a consequence of) Examine pate has been signed by the attending physician and page 2 should be detached for use as the burial-transit certificate be executed that initiated events resulting in death) Last Due to (or as FHX To MF  $\int_{O}K$   $\int_{C}F$   $M^2$ Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) Pher significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed PHUSILANI 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? this certificate has funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Cther: 4 Nursing Home 5 esidence 6 Other (Specify) 1 🗌 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DQA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident or Attend after death Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide To the Hospitel o within 24 hours aft To the Funerel Dicompletely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) signed (Morth, Day, Year) 29b. Signature and title of certifier 20 8503 Arlington Blvd., #200 30. Name and address who completed cause th (Item 23a) (Type of perso NS501 M.D. Fairfax, VA 31. Date filed (Mooth, Day Year) Registrar's Signature State 28 2005 Registrar

		-	State Amend Item	State of M	laryland/l r Dr.,G8	Depa	rtment of 15712/0 tificate	Health : 5 <b>dhb</b> 1 <i>Death</i>	and Men	ntal Hyg	jieņe eg. No. O	105	16194
	Physicia /Medic	an	1. Decedent's Name (First, Middle, William E. Wo							Date of Dea Month pril	th Day	2005	3. Time of Death 1:55 p M
	Examin		4a. Facility Name (If not institution, Union Hospita		r)			ton			Ced	unty of Death	
	Funeral Director		245-34-3879	.Sex 7.A 1XXIM 2□F	nge (In yrs. last bi	rthday) Yrs.	If Under 1 Ye Months Day		Min. 8. 1	Date of Birth Month, Day	928	Cou	place (State or Foreign ntry) Carolina
	Maryland f show	tor	Usual Residence of Decedent  10a. State 10b. County  MD (	Cecil	10c. City, Tow	<sub>vn or Lo</sub> Lkto							10d. Inside City Limits 1 XYes 2 No
	3a or 28a	i Director	10e. Street and Number 19 Peach Rd.				10f. Zip Code 2192			1	I0g. Citizer USA	n of What Cou	ntry?
036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hyglene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic avant, the Medical Eraninar must be rediffed at	by Funerai	11. Marital Status  1 ☐ Never Married 2 ☑ Marrie 3 ☐ Widowed 4 ☐ Divorced	12. Was Deceder Armed Forces d 1  Yes 2  If Yes, Give Year or Dates	s? <b>⊻</b> No	l	Was Decedent of Yes, specify C	uban, Mexica	in, Puerto Rica			Race - Ameri Black, White, pecify: Wh:	etc.
Maryland 21215-0036	within 72 houene.	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)			(Give life. L	dent's Usual Ockind of work do OO NOT use ret	ne during mos ired)	st of working	,		of Business/Ir SSiona	
land 2	12 should be filed within and Mental Hygiene. Fia marked other than "raumatic avant, the Me.	a)	17. Father's Name (First, Middle, Li Rev. Lee Woodruf		'				er's Name <i>(Fii</i> tie Bro		Maiden Su	mame)	
	1 and 2 shou Health and N Ism 27 is ma		19a. Informant's Name/Relationshi Verna Nowell	o (Type, Print)	3	04 I	ng Address (Stree Peach Ci		Smyrna,	DE 1	9977		
Baltimore,	permit. Pages 1 a Department of He important: If itam any injury or oth		20a. Method of Disposition 1 □ Burial 2 XCremation 3 □ Donation 5 □ Other (Specific Control of Con		cemete	ary, cren	sition (Name of natory or other ) nation S	Service	Date es 5/3/		_	rna, Dl	
Balt	permit. Depart import any inj		21. Signature of Funeral Service Li	inerster 1	10-1375	29	aries fi S. Mai	n St.	Smyrna	DE 1	9977		
	Pnysician /Medical Examiner		23a. Part1. Enter the disease, or canock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	a. Respanded to the control of the c	Atory as a consequence	oof):	istresi		/ N	Did-4			Approximate Interval Between Onset and Death
8760,	rate be executed obysician and the burial-transit	dical Examine	If any, fracting to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	c	as a consequence	,							
.O. Box 6	the death certific by the attending pached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal deat at time of death		Ectopic pregna Other (specify				23d	I. Date of deliv Month	rery Day Year
rds, P.	quires that an signed t uid be det	þ	Part II. Other significant condition	s contributing to death	but not resulting	in the u	nderlying cause	given in Part	l. 		bacco use es 2 🗆 N	_	the cause of death? bably 4 Unknown
Vital Record		Completed	Renal FAI	INC						24a. Was a autop perfor	sy	prior to co death?	opsy findings available ompletion of cause of
of Vita	Physician: this certific	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ▼No	Hospital: 1 Timpa	de la constitución de la constit		IL 3 DOA	Other: 4 🗆 N	e of Death (Ci	5 🗌 Resid	ence 6		fy)
Division o	or Attending ter death. iractor: After ir by the fune	Certification;	27. Manner of Death  1 Natural  2 Accident  3 Suicide  4 Homicide  5 Pending  investige  6 Could nodeterming	ot be 28e. Place of	Injury 28b.  Injury - At home, fetc. (Specify)	Time of Injury	ρ	njuryat Work? □ Yes 2 ☐	]No	Location (S	treet and N		al Route Number,
_	Hospital 4 hours Funaral lely filled	Medicai Ce	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the be xaminer: On the basis and manner	of examination a	ge, deat nd/or in	h occurred at th vestigation, in m	e time, date a ny opinion, de	nd place, and ath occurred a	due to the o	cause(s) an date and pla	d manner as s	stated. to the cause(s)
)	To the within 2 To tha complei	Me	29b. Signature and title of certifier	The	20m			ense number	59		Apu	igned (Month,	Day, Year)
	10			Jr. MD U	nion Hos	oi ta	al Elkto	on MD 2	<sub>21</sub> 921		-1		
	Sta Registi		31. Date filed (Month, Day, Year) MAY 1 2 200	32. Regi	strar's Signatur	arte	,						

		•	For State Registrar	State of Ma	aryland / Depa <i>Ce</i>	artment of H			giene	)5	16195
			1. Decedent's Name (First, Middle, Last,	1		7		2. Date of Dea Month		Vana	3. Time of Death
	Physicia /Medic		Leo Lothar Weinber	rger				April		Year 1005	5:00 P M
	Examin	_	4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Deat	th	4c. County	of Death	
			2605 Blaine Drive			Chevy Ch			Montg		
	Funeral Director		066-18-4545	7	e (In yrs. last birthday) 81 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		923	9. Birthp Cour. Gern	
	and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	ocation				1	Od. Inside City Limits
	Maryl f sho	ō	MD Montgomer	су	Chevy Cha	se					1 X Yes 2 □ No
	28a	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Cour	ntry?
	h with	O E	2605 Blaine Drive			20815			United	Stat	es
	deat	Funerai	11. Marital Status	12. Was Decedent Armed Forces?		Was Decedent of H	ispanic Origin? (S	Specify Yes or No-		e - Americ	
90	or its		1 ☐ Never Married 2 ☐ Married	1 X Yes 2 □	No 1943-	1 ☐ Yes 2 🔀 No	Specify:	10 / 1104/1 (101)		v: Whit	
ő	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show the Medical Examination at the incitified at	d by	3 X Widowed 4 □ Divorced	Year or Dates:	1740		- 4i - m				
15-	n 72 n "nat	Completed	15. Decedent's Edu (Specify only highest grad	e completed)	(Give	dent's Usual Occup kind of work done of DO NOT use retired	durina most of wo	rking	16b. Kind of B	usiness/ind	dustry
212	iene.	E O	Elementary/Secondary (0-12)	College (1-4or :	Pres:	ident			Insuran	ce Ag	gency
פַ	e filec othe vent,	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle,	Maiden Surnar	ne)	
/lar	Ments Ments urked	ToE	Moritz Weinberger				Bertha	Herz			
Maryland 21215-0036	and and ls ma		19a. Informant's Name/Relationship (Ty	rpe, Print)		ng Address (Street					Code)
, Z	l and lealth m 27 her tr		Myra Penders - Dat	ighter		Patriot D					Olut-
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other traumatic event, If a Medical Examiner mast be notified at once.		20a. Method of Disposition  1 Burial 2 Cremation 3 F		20b. Place of Dispo cemetery, cre				20c. Location	-	WII, State
Ħ	it. Partmer	T	<ul><li>4 ☐ Donation 5 ☐ Other (Specify)</li><li>21. Signature of Funeral Service Licens</li></ul>		Mt. Leban	on Cemete  2. Name and Addres		29/2005	Adelph:	1, MD	
Ba	Depa Impo any i		Nanny A. K	ucan V	J H	ines-Rina 1800 New	ldi Fune Hampshir	e Ave Si	Iver Sp	ring,	MD 20904
			23a. Part 1. Enter the disease, or compleshock, or hear failure. List only or	ications that caused ne cause on each li	d the death. Do not en ne.	ter the mode of dyin	g, such as cardia	c or respiratory arr	rest,		Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	e Cancer	<u> </u>					
ľ	Examiner		1	Due to (or as	a consequence of):						
	100	e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequence of):					-	
	od ansit	Examine	cause. Enter Underlying Cause (Uleases of Jun) that initiated events	•							
o,	an an an irial-tr	Exa	resulting in death) Last	Due to (or as	a consequence of):						
8760,	cate be executed physician and the burial-transit	dicai		d						-	
9	ertific ling p	Mec	IF FEMALE:	10- 16 ves sutseme							
Вох	death certific e attending p ed for use as	Physician/Me	in the past 12 months?	3c. If yes, outcome 1□Live birth 4□Pregnant a	2 Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)				te of delive Inth	ry Day Year
o.	0 0 0	iysid	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	tune or death 5	Other (specify)					
Д	law requires that the as been signed by th 2 should be detache	by Pr	Part II. Other significant conditions co	ntributing to death b	out not resulting in the u	ınderlying cause giv	en in Part I.	23e. Did to	bacco use conf	ribute to th	e cause of death?
Records,	quires in sign							1 □ Y	es 2🕅No	3 ☐ Prob	ably 4 □Unknown
000	law requi	plet						24a. Was a		Were auto	osy findings available inpletion of cause of
ĕ	9 4 9	Completed						perfor	med?	death? 1 🗌 Yes	
Vital	ician: Th certificate rector, pag	Bec	25. Was case referred to medical examiner?					ath (Check only or			
of V	Phyaician: this certific ral director,	2	1 ☐ Yes 2 🔀 No	lospital: 1 ☐ Inpatie			4 🗀 Nursing r	Home 5∏ Resid			')
on c	Jing After fune	ion	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year) 28b. Time of Injury	Worl	/ at <br Yes 2 □ No	28d. Describe h	ow injury occur	red	
Division	l or Attending after death. Director: Afte I in by the fune	ficat	2 Accident investigation 3 Suicide 6 Could not be 4 Haminide determined	28e. Place of Ini	jury - At home, farm, st		163 2 110	28f. Location (S	treet and Numi	er or Rura	I Route Number,
Ω	P S F C	Certification:	4  Homicide determined		c. (Specify)	, , , , , , , , , , , , , , , , , , , ,		City or Tow			
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	edical (	29a. Certifier 12 Certifying Phy (Check only one)	sician: To the best ner: On the basis o and manner st	of my knowledge, deat f examination and/or in ated.	h occurred at the tin evestigation, in my o	ne, date and place pinion, death occu	e, and due to the curred at the time, d	ause(s) and ma late and place,	anner as st and due to	ated. the cause(s)
	Mithin Fo the	Me	29b. Signature and title of certifier			29c. License	e number	2	29d. Date signe	d (Month, i	Day, Year)
	(0)		· MAMM	cm.	17	53177			04/27/2	005	
	(~		30. Name and address of person who co			Print)					
			John Wallmark, MD	9707 Med	ical Cente	r Drive S	uite-300	Rockvil	le, MD	20850	
	Sta Registr		31. Date filed (Month, Day, Year)  APR 2 8 200!	2. Registr	rar's Signature	de					

			-	State of Ma	ryland / Depa	artment of H			9	DIC.	
		•	For Stata Registrar			tificate of		_	Reg. No. 0	15	16196
	Physicia		1. Decedent's Name (First, Middle, Last)					2. Date of De Month	aath Day	Year	3. Time of Death
	/Medic		CHARLES LEVON WARRE					April		05	8:21 A <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, give str Civista Medical			LaPla	r Location of Deat	n	4c. County	rles	
	Funeral		5. Social Security Number 6. Sex	7. Age	(In yrs. last birthday)	If Under 1 Year  Months Days		8. Date of Bir	rth	9. Birthpl	lace (State or Foreign
	Director		213-24-3403 **	1 2 F	76 Yrs.	Months Days	Hours Min.	DECEMBE	<sup>17</sup> , 14, 1928	WASHII	NGION, D.C.
land	MQ III		Usuel Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	cation				10	0d. Inside City Limits
Mary	ns l-e	tor	MARYLAND CHARLES		WALDORF						¹¶Yes 2□No
ith the	or 28	Director	10e. Street and Number			10f. Zip Code	2601		10g. Citizen of		-
.1215-0036 within 72 hours after death with the Maryland	s 23e	erai	11784 OAK MANOR DRI	VE . Was Decedent E	ver in II S 12.1		0601	pecify Ves or N	UNITED	o - America	
fter de	r Item	Funerai	11. Marital Status 12  1▲ Never Married 2 Married	Armed Forces? 1 □XYes 2 □ N	∘ 1951 ⊦	Was Decedent of H f Yes, specify Cubi		o Rican, etc.)	Blad	ck, White,	
<b>215-0036</b> thin 72 hours aff	FX3	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1953	1□Yes 2ŪXNo	Specify:		Specify	BLAC	CK
<b>15-(</b>	"natu	Completed	15. Decedent's Educa (Specify only highest grade o	tion completed)	16a. Deced	dent's Usual Occup kind of work done DO NOT use retired	oation during most of wo	rking	16b. Kind of B	usiness/Ind	dustry
12.	iene.	ошо	Elementary/Secondary (0-12)  11TH GRADE	College (1-4or 5-	F) {	BORER	<b>-</b> /		CONSTR	UCTIO	ON
RE IIIe	al Hyg I othe Vent.	Be C	17. Father's Name (First, Middle, Last)						, Maiden Suman	•	•
AR Yan	Mental	101	CHARLES EDWARD WARR				LAURA EI				
Mar	f Health and Mental Hygiene. Item 27 is marked other then "naturel", or Items 23e or 28e-1 show other treumatic event, the Madical Examiner must be nutified at		19a. Informant's Name/Relationship (Type DEBRA WARREN / DAUG			OAK MANO			-		20601
E I an	f Health item 27 i		20a. Method of Disposition		20b. Place of Dispo cemetery, crer			Date	20c. Location -		wn, State
	o == ==		1 XBurial 2 ☐ Cremation 3 ☐ Rer '4 ☐ Donation 5 ☐ Other (Specify)		MARYLAND VE	LERANS CEME	TERY   MAY	3, 2005	CHELTENHA	m, mar	YLAND
Salt Salt	Department o Importent: If any injury or once.		21. Signature of Funeral Service Licensee	Johns		CORNICH FUN					90000
	0 = e 0		LYDIA C. THORNION JOH 23a. Part1. Enter the disease, or complica	MSUN MUUS	100	439 LIVINGS				ND 20	Approximate
	watatan		shock, or heart failure. List only one Immediate Cause (Final	cause on each line	dion	IMAM	I Fai	1110			Onset and Death
//	ysician Medicai		disease or condition resulting in death)	Due to (or as a	consequence of):	JIIII C	1 101	iwic		0	- / Illian
Ex	kaminer		Sequentially list conditions.	Se	0515						1days
P	sit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	consequence of):	ENATE	OTAT	PAINS	VII AR	-	7dala
<b>760,</b> te be executed	al-tran	Examiner	that initiated events c. resulting in death) Last	Due to (or as a	consequence of):	-////-	-0-1011	1100	ACTIO	TION	1)
	hysician and the burial-transit	cail		C	OPD E	XACEI	RB4TA	ON			
c 68	within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending ph completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Med	IF FEMALE:		,						
Box eath cert	attend for us	ian/	in the past 12 months?	: If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at t	2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)	у		23d. Da Mo	te of deliver nth	ry Day Year
P.O.	by the	hysic	1 Yes 2 506 9 Unknown	9□ Unknown	anie or death 3 c						
S, P	gned b	by PI	Part II. Other significent conditions contri	buting to death bu	I not resulting in the u	nderlying cause giv	ven in Part I.	-			e cause of death?
ord equire	en si	ted	19/10/10/04	Caric	ej			10	2 □ No	3 Proba	ably 4 Unknown
e law	has b	Completed	COPD					24a. Was	an 24b. psy prmed?	Were autoporior to condeath?	osy findings available appletion of cause of
al F	ficate or, pag	e Col	25 Was asso referred to modical				OC Diseased Day	1 Tes	30 Mg		2 🗆 No
Vit	s certi	To Be	25. Was case referred to medical examiner?	spital: Inpatier	nt 2 ER/Outpatier	at 3 DOA Oth	200	ath <i>(Check only o</i> Iome 5∏ Resi	dence 6 Oth	er (Specify	-}
O O	ter thi		27. Manner of Death	28a. Date of Injury (Month, Day	28b. Time of				how injury occur		/
SiOI	eath. Ior: Al the fu	catic	2 Accident investigation 3 Suicide 6 Could not be			M 1 🗆	Yes 2 □ No				·
Division of Vital Records,	Direct Direct in by	Certification:	4 Homicide determined	28e. Place of Inju building, etc.	ry - At home, farm, str . (Specify)	eet, factory, office		City or To	Street and Numb wn, State)	er or Hurai	Houle Number,
Spitel	nerel rilled		29a. Certifier Certifying Physic	ian: To the best o	f my knowledge, deatl	n occurred at the tir	me, date and place	, and due to the	cause(s) and ma	inner as sta	ated.
he Ho	in 24 h	Medical	(Check only 2 Medical Exemine	r: On the basis of and manner stat	examination and/or in ted.			irred at the time,			
Tol	To 1	Σ	29b. Signature and title of certifier	Mun	nomo	29c. Licens	se number		29d. Date signe	(Month, I	Day, Year)
			30 Name of the last	pleted source of the	ath (Itam 22a) (Time		060181		46	110	<b>10</b>
R	1		30. Name and address of person who com Stacie Gump, MI		Old Line		r. Sto	202 ⊑	Jaldonf	Μħ	20602
(۱)	Sta		31. Date filed (Month, Day, Year)	32. Pagistra	r's Signature			~~~ · · · · · · · · · · · · · · · · · ·	·a = U V I I	4 111V	<del>20002</del>
	Registr	ar	APR 2 9 200	Marie	w # A	seed 9					

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Edward Lee April Wolffe 25 2005 11:30 pm /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 1701 Perseus Road Church Creek Dorchester If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 M 2□ F Yrs. Director 579-48-9564 1929 Washington DC Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f ehow traumatic event, the Madical Examiner must be notified at 1 ☐ Yes 2 X No Directo Dorchester Church Creek 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1701 Perseus Road or iteme 23e 21622 USA Funeral Baltimore, Maryland 21215-0036 arphi12. Was Decedent Ever in U.S. Armed Forces?

192 Yes 2 D No If Yes, Give Year or Dates: 51 - 53 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filled within 72 hours after d Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel", or item any injury or other traumatic event, the Medical Examples 1988. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: δ Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) chemical engineer plastics 12 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Samuel Wolffe Alice Kriegel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Renate Wolffe P. O. Box 162, Church Creek, MD wife 21622 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🕱 Cremation 3 ☐ Removal from State ` 4 ☐ Donation <sup>\*</sup> 5 ☐ Other (Specify) Salisbury Crematory 4/27/05 Salisbury, MD Funeral Service Licensee 21. Signatur 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Pant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician gastric Cancer weeks disease or condition resulting in death) /Medical Jue to (or as a consequence of): Examiner coronary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner law requires that the death certificate be executed use as the burial-transit diabetes meili tu that initiated events resulting in death) Last Due to (or as a consequence of) the attending physicien Division of Vital Records, P.O. Box 68760. Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months? ō Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 PNo 1□ Yes Hospital or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☑ No this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Certification: 1 Natural Injury 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funerel Direct 4 🗌 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 40059973 haron 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cambridge, MD 2/6/3 Johnson 100 Bramble St 32 Registrar's Signature 31. Date filed (Month, Day, Year) APR 2 8 2005 Registrar

**JET** Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend I per me g843 5-20-05 vt State of Maryland? Department of Health and Mental Hygiene 05-03133 Margo Baker 1 - State Registrar Certificate of Death Reg. No. 🛶 1. Decedent's Name (First, Middle, Last) Anginette 2. Date of Death Month Year 1ARGO **Physician** HNNEHE May 05 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 4000 Blk. Clifton Avenue Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1□M 2**1**F Months Days Hours - Yrs. 18·60·43K Director Usual Residence of Decedent 10a, State 10d. Inside City Limits 10b. County 10c. City, Town or Location f Health and Mental Hygiene. item 27 is marked other then "neturel", or Items 23a or 28e-f shov other treumetic event, the Medical Examinar must be notified at 1 Yes 2 No Completed by Funeral Director DATIMORE Of. Zip Code Street and Nun 10g. Citizen of What Country? U.S.A. 14. Race - American Indian, Black, White, etc. 11. Marital Status Yes 2 No filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) ABORER Pages 1 and 2 should be filed a nent of Health and Mental Hygic ent: If item 27 is marked other 17. Father's Name (First, Middle, Last) To Be BERNARD WHIHON DAVAHTER MD 20a. Method of Dispos Place of Disposition (Name of cemetery, crematory or other place) BATIMORE, MARYLAND 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State = 5 permit. Page Department ( Importent: If any injury or GREEN MOUNT `4 ☐ Donation 5 ☐ Other (Specify) WOHN C. GREENE FUNERAL HOME 21. Signature of Funeral Service Licensee lu BAUTI MORE, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. mmediate Cause (Final Physician Multiple stab and culting wounds disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) by Physician/Medical Examiner the burial-transit Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): IF FEMALE: use If yes, outcome of pregnancy 1☐Live birth 2☐Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy į in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 1 🗌 Yes 21 No 3 ☐ Probably 4 ☐ Unknown director, page 2 should Completed 24a. Was an ayltopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No ้อร 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1X Yes 2 □ No Medical Certification: To 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Xother (Specify) Scene 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Division 1 Natural Bo willy 5 Pending subject out and straked s after death. investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 9:22 PM 1 Tes 2 Accident 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by Ford Block Clifton Are Batomore VID unknown within 24 hours a To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

\*\*Control Death occurred at the time, date and place, and due to the cause(s) and manner as stated.

\*\*Control Death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME Jast May 06 2005 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person 111 Penn Street Baltimore, Maryland 21201 1ashaZ Greenberz 32. Registra s Signature 31. Date filed (Month, Day, Year) State MAY 1 3 2005 Registrar

		1	For State Registrar	State of Maryl		artment of Hertificate of L			ene 005	16199
	Physici /Medic		1. Decedent's Name (First, Middle, Las Autumn	st)	Blo	rsko		2. Date of Death Month	Day Year 2005	3. Time of Death
	Examir Funeral Director	ier	<ol><li>Social Security Number 6. S</li></ol>	ins Hospita	yrs. last birthday)	Ab. City, Town, or Baltime If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Jan. 29,	4c. County of Dea	thplace (State or Foreign ountry)
	D		Usual Residence of Decedent  10a. State 10b. County		. City, Town or Lo			Jan. 29,	2004   Ma	ryland  10d. Inside City Limits
	with the Ma s or 28a-f s be notified	Director	MD Howard  10e. Street and Number  6709 Lowes Lane		Elkridg	10f. Zip Code 21075		10	g. Citizen of What C	1 ☐ Yes 2 ☒ No ountry?
036	be filed within 72 hours after death with the Maryland that Hygiene.  dother than "natural", or items 23e or 28e-f show event, the Medical Exambar must be notified at	by Funeral	11. Marital Status  1 X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever i Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of His f Yes, specify Cubar I ☐ Yes 2♥ No	spanic Origin? (Spen, Mexican, Puerto	ocify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	te, etc.
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Maryland	should be file and Mental Hy s marked oth umatic event	To Be (	17. Father's Name (First, Middle, Last)  Timothy Raymond				18. Mother's Name	Alyce Cı	coss	
	nd 2 suith an 27 is r trau		19a. Informant's Name/Relationship (  Jennifer Blasko -	mother	6709	Lowes La	ne, Elkri		City or Town, State, 21075	Zip Code)
Baltimore,	of of r		20a. Method of Disposition  1  ☐ Burial 2 ☐ Cremation 3 ☐  14 ☐ Donation 5 ☐ Other (Specify)	/) M	eadowrid	sition (Name of natory or other place ge Mem. P	ark 5/12	2/2005	Elkridge	
Ball	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licer		Ga 72	50 Washin	fman Fune	L., Elkri	idge, MD	idge MP, Inc. 21075
	Physician /Medical		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line.	Crane	er the mode of dying	, such as cardiac o	r respiratory arres	st,	Approximate Interval Between Onset and Death
	Examiner			D	5175 65	21 CARDIS	27			D4-J1
·,	ate be executed thysician and the burial-transit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a con	CEMOUS	「悪シーへの	S OF HET	OPHILOS	これらからかん	Days
68760,	ficate be physicials to the bur	edicai	(	d						
.O. Box	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 N No 9 ☐ Unknow	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
Φ.	w requires that been signed b should be deta	by	Part II. Other significent conditions of	ontributing to death but not	resulting in the ur	nderlying cause give	n in Part I.	23e. Did toba	M	o the cause of death? robably 4 □Unknown
Vital Records,	ician: The law re certificate has ber rector, page 2 sho	Completed						24a. Was an autopsy performe 1 Yes 2	prior to death?	utopsy findings available completion of cause of 2 No
r Vit	ysic Is ce direc	To Be	25. Was case referred to medical examiner?  1 Xes 2 No	Hospital: 1  Inpatient	ER/Outpatien	t 3 DOA Othe	26. Place of Death  T: 4 \( \text{Nursing Hor} \)		ce 6 ☐Other (Spe	city)
ion of	ng flei		27. Manner of Death Natural 5 Pending Accident investigation		28b. Time of Injury	Work'	at ? es 2 □ No	28d. Describe how	injury occurred	
Division	s after de s Directe	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injury - A building, etc. (Sp	At home, farm, stre ecify)	eet, factory, office	2	28f. Location (Stre City or Town,	et and Number or R State)	ural Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director; A completely filled in by the fu	Medical	one) 2 Medicel Exer	ysicien: To the best of my niner: On the basis of exan and manner stated.	knowledge, death nination and/or inv	estigation, in my opi	inion, death occurre	and due to the cau ed at the time, dat	ise(s) and manner a e and place, and du	s stated. e to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and little of certifier	Halles		29c. License	54361	29c	d. Date signed (Mont	h, Day, Year)
ļ	121		30. Name and address of person who UKA VCICE WA _ A.D	completed cause of death (	(Item 23a) (Type,	Print) 600	N wolf?	( f = . (	385,70M	DD 21287
	Sta Registi	_	31. Date filed (Month, Day, Year)	32. Registrar's S	ignature	0				

			State of Maryland / De	epartment of Health and N	-	•
				Certificate of Death	Rag. I	
и	Physici	an	Decedent's Name (First, Middle, Last)			Day Year 3. Time of Death
	/Medic	al	Lydia Trapp Beyer  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	, <u>, , , , , , , , , , , , , , , , , , </u>	1 2005 5:25 AM M
		×	Glen Meadows	Glen Arm		Baltimore
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	
-	Director		218-22-0509 86  Usual Residence of Decedent	3.	05/20/191	8 Maryland
	72 hours after death with the Maryland naturel', or Hems 23a or 28a-f show disal Examilier must be notified at		10a. State 10b. County 10c. City, Town of	or Location		10d. Inside City Limits
	72 hours after death with the Marylar naturel', or items 23s or 28s-1 show lical Examinet must be notified at	Funeral Director	MD Baltimore Glen			1 □Yes 2XNo
	a or 2	ij	10e. Street and Number	10f. Zip Code		Citizen of What Country?
	ter death Items 23	era	11630 Glen Arm Road - Apt. 148 ACC	21057  13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto		J.S.A.  14. Race - American Indian,
9	or Iter		Armed Forces?  1 X Never Married 2  Married 1  Yes 2  No   Yes 2  No   Yes		Rican, etc.)	Black, White, etc.
21215-0036	urel', c	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:			Specify: White
15-	a within 72 ho piene. r then "natur the Medical	Completed	(Specify only highest grade completed)	ecedent's Usual Occupation Give kind of work done during most of work fe. DO NOT use retired)	ing	. Kind of Business/Industry
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	be filed vital Hygie d other f	Bec	17. Father's Name (First, Middle, Last)		e (First, Middle, Maid	
<u>ya</u>		To E		Lydia T		
Maryland	12 sh h and 7 Is m treum	. 9		Mailing Address (Street and Number or Run 3 Palace Court - Po:		
	1 an Heal em 2					Location - City or Town, State
ē	0 0	1		Luth. Church Cem. 05/12	2/2005 Ton	v Cross Mareland
Baltimore,	artm orte inju		21. Signature of Funeral Service Licensee			Funeral Home, P.A.
Ω.	Dep Imp eny		E. S. Lassach	11750 Belair Road -		
			23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.		or respiratory arrest,	Approximate Interval Between Onset and Death
	Physician /Medical		resulting in death)	NAL FAILURE	2	24 HOURS
	Examiner		Due to (or as a consequence of)	TIVE CARDIA	IC FAI	LURE 12 min NIH
		Jer	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of)	:	- ( ) ) (	1210101
	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events  c.   Due to (or as a consequence of)  The provided in the consequence of	ENSION		20 YEARS
,092	ate be executed hysician and he burial-transit	i Ex	resulting in death) Last Due to (or as a consequence of)	:		
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Box (	leath certificat attending phy I for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	- C-		23d. Date of delivery
	death	sicia	in the past 12 months?  1 Ves 2 No 9 Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month Day Year
P.0	that the de ed by the a detached	Phys	9 Unknown	The state of the s	Oce Didaster	
	es be	by	Part II. Other significant conditions contributing to death but not resulting in the PARKINS ONS DISPLACE	ne underlying cause given in Part I.		o use contribute to the cause of death?  2 No 3 Probably 4 Unknown
Vital Records,	w requir been si should	Completed	OSTEO ARTHRITIS		24a. Was an	24b. Were autopsy findings available
Re	he lav e has age 2	omo	OBESITY DECUBIT	US VLLER	autopsy performed	prior to completion of cause of death?
ita		a)	25. Was case referred to medical		1 ☐ Yes 2 🔀!	No 1 ☐ Yes 2 ☐ No
of V	Physicien: this certific ral director,	To B	examiner? 1   Yes 2   No   Hospital: 1   Inpatient 2   ER/Outp		me 5 Residence	6 ☐Other (Specify)
n	ding P h. After t funera	lon:	27. Manner of Death  1 XNatural 5 Pending  28a. Date of Injury (Month, Day Year)  28b. Tin	iry Work?	28d. Describe how in	jury occurred
Division	deat deat ctor: / the	ertification	2 Accident investigation 3 Suicide 6 Could not be determined to the determined state of the stat	M 1 Yes 2 No	28f. Location (Street	and Number or Rural Route Number,
Ďį∧		ertii	4 Homicide determined building, etc. (Specify)	, disot, lastery, error	City or Town, Sta	
	To the Hospital or within 24 hours afte To the Funerel Dir completely filled in	caic	29a. Certifier (Check only (Check only Medical Examiner: On the basis of examination and/	leath occurred at the time, date and place,	and due to the cause	(s) and manner as stated.
	To the H within 24 To the F complete	Medical	and manner stated.			
	To To Con	~	29b. Signature and title of certifier	29c. License number D 5/2-28		Date signed (Month, Day, Year)  5/11/2005
,	A		ham my / of worth			
	'')		RAMANA GOPACAN MD 2	EMOLLING CROSS	LEOURDI. #	157 MD 21228
	Sta					
	Registr	ar	MAY 1 3 2005	your		

Usual Residence of Decedent    10a. State   10b. County   10c. City, Town or Location	4:45 pm M  mery  Inthplace (State or Foreign ountry)  Llinois  10d. Inside City Limits  1 Yes 2 No  XX  ountry?  Lates  Grican Indian, te, etc.
### Ann Karlovsky Bolton  ### 4. Facility Name (If not institution, give street and number)  ### 14431 Traville Garden Circle #201D  ### 15. Social Security Number  ### 52-9925  ### 10b. County   4:45 pm M  mery  Inthplace (State or Foreign ountry)  Llinois  10d. Inside City Limits  1 Yes 2 No  XX  ountry?  Lates  Grican Indian, te, etc.	
4a. Facility Name (If not institution, give street and number)  14431 Traville Garden Circle #201D  Funeral Director  Funeral Director  5. Social Security Number 6. Sex 1	nery Inthplace (State or Foreign country) Llinois  10d. Inside City Limits  1 Yes 2 No  Nountry?  Lates  Grican Indian, te, etc.
Funeral Director  Funeral Dire	thplace (State or Foreign ountry) Llinois  10d. Inside City Limits
Usual Residence of Decedent  10a. State 10b. County  MD Montgomery Rockville  10e. Street and Number  10f. Zip Code  10g. Citizen of What Cor  10f. Zip Code  10g. Citizen of What Cor  10f. Zip Code  10g. Citizen of What Cor  11g. Marital Status  11g. Marital Status  11g. Marital Status  11g. Marital Status  11g. Never Married 20g Married  1	Ilinois  10d. Inside City Limits  1 Yes 2 No  Nountry?  Lates  Prican Indian, te, etc.
Usual Residence of Decedent  10a. State 10b. County  MD Montgomery Rockville  10e. Street and Number  10f. Zip Code  10g. Citizen of What Cor  10f. Zip Code  10g. Citizen of What Cor  10f. Zip Code  10g. Citizen of What Cor  11g. Marital Status  11g. Marital Status  11g. Marital Status  11g. Marital Status  11g. Never Married 20g Married  1	Ilinois  10d. Inside City Limits  1 Yes 2 No  Nountry?  Lates  Prican Indian, te, etc.
MD Montgomery Rockville  10e. Street and Number 10g. Citizen of What Company 10g. Citizen of What Compa	ountry?  cates erican Indian, te, etc.
Joseph Karlovsky    Frances Srain Karlovsky   19a. Informant's Name/Relationship (Type, Print)   19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2)   Katherine Hartley/Daughter   18436 Flower Hill Way Coitherships   18436 Flower Hill	ountry?  cates erican Indian, te, etc.
Joseph Karlovsky    Frances Srain Karlovsky   19a. Informant's Name/Relationship (Type, Print)   19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2)   Katherine Hartley/Daughter   18436 Flower Hill Way Coitherships   18436 Flower Hill	cates erican Indian, te, etc. 7hite
Joseph Karlovsky    Frances Srain Karlovsky   19a. Informant's Name/Relationship (Type, Print)   19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2)   Katherine Hartley/Daughter   18436 Flower Hill Way Coitherships   18436 Flower Hill	cates erican Indian, te, etc. 7hite
Joseph Karlovsky    Frances Srain Karlovsky   19a. Informant's Name/Relationship (Type, Print)   19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2)   Katherine Hartley/Daughter   18436 Flower Hill Way Coitherships   18436 Flower Hill	erican Indian, ite, etc. hite
Joseph Karlovsky    Frances Srain Karlovsky   19a. Informant's Name/Relationship (Type, Print)   19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2)   Katherine Hartley/Daughter   18436 Flower Hill Way Coitherships   18436 Flower Hill	hite
Joseph Karlovsky    Frances Srain Karlovsky   19a. Informant's Name/Relationship (Type, Print)   19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2)   Katherine Hartley/Daughter   18436 Flower Hill Way Coitherships   18436 Flower Hill	
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Joseph Karlovsky    Frances Srain Karlovsky   19a. Informant's Name/Relationship (Type, Print)   19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2)   Katherine Hartley/Daughter   18436 Flower Hill Way Coitherships   18436 Flower Hill	
Joseph Karlovsky    Frances Srain Karlovsky   19a. Informant's Name/Relationship (Type, Print)   19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2)   Katherine Hartley/Daughter   18436 Flower Hill Way Coitherships   18436 Flower Hill	ident
Joseph Karlovsky    Frances Srain Karlovsky   19a. Informant's Name/Relationship (Type, Print)   19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2)   Katherine Hartley/Daughter   18436 Flower Hill Way Coitherships   18436 Flower Hill	
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Katherine Hartley/Daughter 18436 Flower Hill Way Coithard	9
Care I Tower IIII way, trail herenitrit will	
Katherine Hartley/Daughter  18436 Flower Hill Way, Gaithersburg, MD  20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City or cemetery, crematory or other place)	
Chesapeake Crematory    Chesapeake Crematory   5/11/05   Beltsville	e, m
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,	Approximate
snock, or heart failure. List only one cause on each line.	Interval Between Onset and Death
/Medical // Medical //	
Examiner Examiner	
Sequentially list conditions, if any, leading to immediate cause. Enter U dentying Cause (Disease or injury	
to a use. Enter U denting Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
pennogo de qui pignis skided to pennogo de que penn	
d.    Second   Control   C	
So S	livery
in the past 12 months?    Section of Death   Sectio	Day Year
in the past 12 months?  1   Yes 2   No 9   Unknown 9	
1 Yes 2 XNo 3 Pro	obably 4 □Unknown
2) 을 다 보다 보	utopsy findings available completion of cause of
Professional autopsy prior to death?  1 Yes 2 No 1 Yes	2 No
performed?   death?	
上	cify)
27. Manner of Death 28a. Date of Injury 28b. Time of Injury at Work? 28d. Describe how injury occurred Injury 28d. Describe how injury occurred	
1   Matural   5   Pending   (Month, Day Year)   Injury   Work?     2   Accident   investigation   3   Suicide   6   Could not be determined   4   Homicide   Homicide   City or Town State   State   State   City or Town State   State   City or Town State   State   City or Town State   S	
27. Manner of Death  1 XX atural 5   Pending investigation 3   Suicide 4   Homicide   Homicide   All Homicide	ıral Route Number,
29a. Certifier (Check only one)  29a. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due and manner stated.	stated. to the cause(s)
one) and manner stated.  29d. Date signed (Month)	
$\frac{1}{2}$	, _u, , , oai /
May 10, 2	005
	005
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	005
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	005

			1 - For State Registrar	State of	Maryland		artmen rtificat				_	giene Reg. No	2 [] [	15	162	02
	Physic	ian	1. Decedent's Name (First, Mid	dle, Last)							2. Date of De Month	Da	ıy	Year	3. Time o	
	/Medi Exami		Betty Jane Ble  4a. Facility Name (If not instituti Saint Jose	on, give street and numb		er	4b. City,	Town, or	Location of	of Death	on Me		. Count	2005 by of Death Balt	4:4; imor	
	Funeral Director		5. Social Security Number 213-34-2461	6. Sex 1 □ M 2 💢 F	Age (In yrs. last	t birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da			9. Birthp Cour	place (State of	or Foreign
	and	7	Usual Residence of Decedent 10a. State 10b. Count	lv .	10c. City, T	Fown or Lo	ocation								0d. Inside C	its I insite
	Maryl f sho	ō														No No
	28a-	Director	MD Balt:	imore	Tows	on	10f. Zip	Code		-		10a Cit	tizen of	What Cour	ntry?	
	h with		117 E. Susqueh	anna Awanya			212								-14.	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 Ie marked other then "natural", or Items 23a or 28a-1 show other traumatic event, I'm Madical Evertinet must be natilised at	by Funeral	11. Marital Status  1. Never Married 2 Ma 3 Widowed 4 Divorce	12. Was Decede Armed Force 1Yes 2'	es? No			dent of Hi city Cuba	spanic Ori n, Mexicar Specify:	gin? (Spe	cify Yes or No Rican, etc.)		14. Ra	State ce - Amend ack, White, fy: Whit	an Indian, etc.	
5-0	72 hc	eted	15. Decede	ent's Education est grade completed)	1	6a. Dece	dent's Usua kind of wo	al Occupa	ition	t of worki	3.0	16b. K	ind of E	Business/Inc		
121	nen ne.	Completed	Elementary/Secondary (0-12)		or 5+)	life.	DO NOT us	se retired,	)	I OI WOIKII	<i>'</i> 9	Pub	lisł	hing		
	iled w tygie ther ti		12 17. Father's Name (First, Middle	( aat)	I.	Medic	al Ed	litor								
Maryland	12 should be filed within h and Mental Hygiene. 7 le marked other then "Iraumatic event, Iraumatic	Be									(First, Middle,		Sumai	me)		
2	thould d Me mark matic	2	Garney Blevin  19a. Informant's Name/Relation			10h Mailie	a Addraga	(Street o			e Power		. T.	21.4.7	0 / 1	
Ma	and 2 sealth an n 27 le		Steven Webber								Route Numbe				Code)	
ē,	of Health of Health item 27 I	1	20a. Method of Disposition		20b. Place	e of Dispo	sition (Nan	ne of			Towson	4		L 286 - City or To	wn, State	
3	Pages ent of nt: #1		1 ☐ Burial 2 12 Cremation 1 ☐ Donation 5 ☐ Other (				natory or o			M	ay 11					
Baltimore,	permit. Pages. Department of the Importent: if Ite eny injury or ot once.	- 1	21. Signature of Funeral Service		Ches.		ce Cre				005	Belt	csv1	IIe, N	iarylar	nd
m	Depa Depa Impo eny ir		SEN	alel	00000	C	remati	ion a	nd Fu	nera]	Altern	ativ	res			
	Physician /Medical		23a. Part1. Enter the disease, of shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	st only one cause on each	sed the death. In line.	Do not ent	er the mod	e of dying	, such as	cardiac o	Prive E respiratory ar	Balti rest,	Lmor	e, Mar	YLand Approximate Interval Bett Onset and I	e ween
	Examiner		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		as a consequen		AM A	1 1 1 V	nd miles							
		-G	Sequentially list conditions, if any, leading to immediate	D	OLIC CA		HL H	RRE	31							
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	<	RIOSCLE	•	ቸው es	Ann i	C ("N 1 1 2'S /	m/m3 11	AD DE	proc 50000 feet 1	part, gran			
o,	cate be executed obysician and the burial-transit		resulting in death) Last	Due to (or	as a consequen	ce of):	<u> </u>	BKD.	LUVH		HR DI					
8760,	ysicie	dical		d												
9	ntifica ng ph as th	Ned	IE FEMALE.										-			
.O. Box	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 MNo 9 ☐ Unknow#		2 Fetal death	ath 3	Ectopic pro Other (spe					1		te of delive	•	'ear
Д.	that ned b deta	by Pr	Part II. Other significant condit	ions contributing to death	but not resultin	g in the ur	nderlying ca	ause givei	n in Part I.		23e. Did to	bacco u	ise cont	tribute to the	e cause of d	eath?
rds	w requires been sign should be										1 □ Y	es 2	XNo.	3 Proba	ıbly 4 ⊟U	Inknown
Vital Records,	aw rec	ompleted									24a. Was	an /	24b.	Were autor	sy findings a	available
æ	The is ate ha page 2	Шо									autop perfor	med?		prior to con death?	ipletion of ca	ause of
<u>a</u>	(0 -	Se C	25. Was case referred to medica	al	-				26. Place	of Death	1 ☐ Yes (Check only o	2 LANO		1 🗌 Yes :	No No	
	. Si . B	To B	examiner?	Hospital: 1 Inpa	atient 2 ER/	Outpatien	t 3 🗆 DO	A Other	_		e 5 Resid	ence 6	3 □Oth	er (Specify	)	
n of			27. Mariner of D th 1 Natural 5 □ Pendi	28a. Date of It	njury 28t Day Year)	D. Time of Injury	28	Bc. Injury Work			8d. Describe h					
Division	Attending ir death. ector: After by the fune	Certification:	2 Accident invest	igation			M		es 2 🗆 N	10						
	or At	ığı l	4 Homicide determ	nined 289. Place of	Injury - At home, etc. <i>(Specify)</i>	, farm, stre	et, factory,	office		2	8f. Location (S City or Tow	treet and n. State	d Numb )	er or Rural	Route Numb	ber,
	lospitel hours a unerel C		200 Cortifies 11 Continue													
	T 4 T 4	edical	29a. Certifier 1 Certifyi (Check only one) 2 Medical	ng Physician: To the be Examiner: On the basis and manner	ol examination	ige, death and/or inv	occurred a restigation,	it the time in my opi	e, date and nion, death	d place, a h occurre	nd due to the o d at the time, o	ause(s) late and	and ma place,	inner as sta and due to	ted. the cause(s)	
	To the within 2 To the complet	Me	29b. Signature and title of certific	ər			29c.	License	number		2	29d. Dati	e signe	d (Month, D	ay, Year)	
}			1 flen	7				0 30	263			05	5-1	0-0	5	
	n		30. Name and address of persor	who completed cause o	f death (Item 23a	a) (Type, i		net had the	r tem Su' SuJ						_	
_			FRANCIS KHO		7621 DS	SLEP	_DRT	UF T	ายเมา	IN.	MARYL	מועב	(0.4.5	29754		
	Sta	- 41	31. Date filed (Month, Day, Year		strar's Signatur	1 A	oste	,	7 T 100 100		V 11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	V T - 13 May	tons she h	411 W		
	Registr	ar	(817) 7	O EUUS	Aller See	1										

			State of Maryland / Deposition Amend Items 25,27,28a-f per MFCS	artment of Health and M Rifficule /3/2021 hb	fental Hyg R	eg. No. 00	5 16203
	Dhusisi		1. Decedent's Name (First, Middle, Last)		2. Date of Deat		3. Time of Death
	Physici /Medic	al	VIRGINIA S. BOPP 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	MAR.		05 12PM <sup>M</sup>
	Examin	er	MARYLAND MASONIC HOME	BALTIMORE COU	NTY		LTIMORE
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day,	9	Birthplace (State or Foreign Country)
	Director		220~20~7876 1□ M XXF 80 Yrs.	William Days Tiours William	May 20,		Α.
	land		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Loc	ocation			10d. Inside City Limits
	Mary -f she fied	tor	Maryland Baltimore Timon	ium			1 ☐ Yes 2√√No
	n the	Director	10e. Street and Number	10f. Zip Code	1	0g. Citizen of Wha	it Country?
	23a c	al D	1814 Vista Lane	21093		USA	
	tems tems	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13.	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)		American Indian, White, etc.
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinal must be notified at once.	y Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2次□ No	1 ☐ Yes 2√XNo Specify:		Specify:	White
8	2 hour	Completed by	15 Decedent's Education 16a Dece	dent's Usual Occupation		16b. Kind of Busin	ess/Industry
215	hin 7.	ple	(Specify only highest grade completed) (Give Elementary/Secondary (0-12) College (1-4or 5+)	kind of work done during most of work DO NOT use retired)		Baltimore	
21	ad wit	Com	12 yrs. 8 yrs. Tea	cher			Education
Ind	be fill d oth	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name		,	
<u> </u>	d Mer narke	7	Samuel Harry Stormfeltz  19a. Informant's Name/Relationship (Type, Print)  19b. Mailii		May Beni		A- 7'- 0- 4-1
Maryland 21215-0036	d 2 st th and th and traur		Devilence D. Higher (Developmen)	ng Address (Street and Number or Run	350	12.00 to 12.00	
ē,	s 1 an l Heal item 2 other		20a. Method of Disposition 20b. Place of Dispo	sition (Name of	Date Mary	V Land Z 20c. Location - Cit	y or Town, State
Baltimore,	Page: ent o nt: # ry or		↓ □ Burial 2 □ Cremation 3 □ Removal from State     ↓ □ Donation 5 □ Other (Specify) Parkwood	matory`or other place) Cemeterv 4-1-2	2005	Ral+imore	e. Maryland
alti	partm porta porta y inju		1 di kwood			uneral Ho	
<u> </u>	9 9 E 2 8			401 Belair Rd. Bal	ltimore,	Md. 2123	
			23a. Part1. Enter the disease, or complications that caused the death. Do not enishock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac	or respiratory arre	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)				Onset and Death
	/Medical Examiner		Due to (or as a consequence of):	to mylitis			
		ē	Sequentially list conditions, if any, leading to immediate	us nyues			
V	uted d ansit	Examiner	if any, leading to infimediate cause. Enter Underlying Cause (Disease or injury that initiated events		1.1	1	
ò	an an rial-tr	Exa	resulting in death) Last Due to (or as a consequence of):	/ 1	///	1	
68760,	icate be executed physician and s the burial-transit	edical	d	Ĺ	- OVEDBY!	MEDICAL EXAMINER	
_			IF FEMALE:	CERTIFICATI	A APPROVE		
Вох	law requires that the death certif as been signed by the attending .2 should be detached for use a	Physician/M	In the past 12 months?	Ectopic pregnancy Other (specify)		23d. Date of Month	delivery Day Year
P.O.	the di ny the ached	ysk	1 Yes 2 No 9 Unknown	Cition (Specify)			
	s that ned b e deta	by P	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tob	acco use contribu	te to the cause of death?
of Vital Records,	aquire en sig ould b	ed t	Atorsilatu Vasular Disease, Do	meetin, 110 CVA	1 ☐ Ye	s 2□No 3□	Probably 4 Munknown
000	12 S C	Completed	HTW, Reighen Vascular Disea	2e, CAD, Bypan	24a. Was ar	n 24b. Wer	e autopsy findings available to completion of cause of
Œ.	The ate has page	Соп	Curey in 1991, 3/p dx (Dhip	he the potroits	perform	ned? deat	h?
/ita	cian: ertific ector,	Be	25. Was case deferred to medical examiner?		h (Check only one	9)	
of)	Physi this o	2	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatier  27. Manner of Death 28a. Date of Injury 28b. Time o		me 5 Reside	nce 6 Other (	Specify)
O	ding h. After funer	tlon	2 Mocident investigation   April 13,03 Unknow	Work?	Subject		
Division	Atten r deat actor: by the	ifica	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, str	411	28f. Location (Str	reet and Number o	r Rural Route Number,
á	s afte	Certification:	4 Homicide determined building, etc. (Specify)  Nursing home	}	Masonic	Home 30	Internationa
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical (	29a. Certifier (Check only  Medicel Exeminer: On the basis of examination and/or in	h occurred at the time, date and place,	and due to the ca	use(s) and manne	r as stated.
	the H hin 24 the F nplete	Medi	and manner stated.				
1	To To	~	29b. Signature and title of ourifier	29c. License number	28	9d. Date signed (M 3/≥8/0	**
		1	20 Name and address of owner with a sample of a sample of the sample of	1764 Print)		1/20/1	3
	10		30. Name and address of person who completed cause of death (Item 23a) (Type, ROPART 1   Reuto   MD 270 8 Bank	St Beella. Mrs	1212	24	
	Sta	te	31. Date filed (Month, Pay Yea) 1 2005 32. Refistrar's Signature	Coarles			
	Registr		HELL A T COOL DESIGNATION OF Y				

Bopp, UIRGINITY.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For Amend Items 23a,b,c,25 per ME, 1843.05/10/05dab Registrar 23a,b,c,25 per ME, 1843.05/10/05dab 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year BLAIR BETTY PM APRIL 1:55 12 /Medical 2005 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death JOHNS HOPKINS BAYVIEW MEDICAL BALTIMORE CENTER BALTIMORE 8. Date of Birth (Month, Day, Year) 9. Birthinia Country
JUNE 27, 1934WEST If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. **Funeral** 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 M XX 213-32-9740 Director 70 VIRGINI Usual Residence of Decedent with the Maryland 10a State 10h County 10c. City, Town or Location itam 27 is marked othar than "natural", or Itams 23a or 28a-f show other traumatic evant, II e Madical Examination ust be notified at 10d. Inside City Limits Directo 1X Yes 2 No MD. N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1203 GUSRYAN STREET 21224 death U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married 1 Yes XINO þ 3 ₩ Widowed 4 Divorced Specify: WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If itam 27 is marked othar than ' College (1-4or 5+) Elementary/Secondary (0-12) HOUSEWIFE DOMESTIC 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame FLORANUS ALDEN BLAIR WUNITA PEARL SEIFERT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FLORANUS BLAIR/ SON LORING CT., APT. C, BALTIMORE, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) permit. Page Department of Important: If any injury or injury or BAYVIEW CREMATORY 4/14/05 BALTIMORE, MARYLAND 21. Signature of Funeral Service Licenses 22 Name and Address of Eachliller INC. FUNERAL HOME 1901 EASTERN AVENUE, BALTIMORE, MD. 21231 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Systemic Inflammatory Response Syndrome Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician complicating Colectomy /Medical Due to (or as a consequence of): **Examiner** Colonic Obstruction Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit Colorite OBSTRU Due to (or as a consequence of): physician Physician/Medical the 3 Dectopic pregnancy CERTIFICATION APPROVED BY MEDICAL EXAMPLER
5 Other (specific) IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 Live birth 2 ☐ Fetal death 4☐Pregnant at time of death Month Day Year the à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Multiple Sclerosis; Hypertension; Diabetes 2 No 3 Probably 4 □Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy 2 No 2 🗆 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 XYes <del>2X</del> 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? After 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 Yes 2 No 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Box 68760, P.0. of Vital Records, Division To the Hospital or Attanding death. Director within 24 hours a To the Funaral L

Baltimore, Maryland 21215-0036

Medical 29b. Signature and title of certifier REECE

29a. Certifier

(Check only one)

, HD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GOO NORTH WOLFE STREET

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

4147357

T3917 APPIL 12 2005

29d. Date signed (Month, Day, Year)

21287

BALTIMORE, MARYLAND

31. Date filed (Month, Day, Year) MAY 1 0 2005

BURNS III 32. Registrar's Signature

State

Registrar

		•	For State Registrar	State of M	Maryland	-	artment <i>rtificate</i>			and Me		iene g. No.	05	16205			
			1. Decedent's Name (First, Mide	dle, Last)							2. Date of Death Month	n Day	Year	3. Time of Death			
	Physicia /Medic		IRENE	C	BE	RNSTE	IN				MAY	10	2005	12:10 FM			
	Examin		4a. Facility Name (If not instituti		on, give street and number)				Location o	of Death		4c. Count	c. County of Death				
			UNION MEMORIA  5. Social Security Number		Age (In yrs. Ia	ast hirthday)	BA If Under 1		MORE If Under 2	24 Hrs.	8. Date of Birth	N/A		place (State or Foreign			
Н	Funeral Director		218-40-2051	1 □ M X2X F	90	Yrs.		Days	Hours	Min.	NOV. 10,	1914	PA	ntry)			
	υ		Usual Residence of Decedent														
	arytan show d st	_	MD BAI	'y LTIMORE	10c. City	Town or Lo							,	1 ☐ Yes 2√√No			
	8a-f	Director		JI II'OKE		DALI.	IMORE	2-1-	-		4/	og. Citizen of	What Cou				
	72 hours effer death with the Maryland Insturel; or Items 23s or 28s-f show disal Examiner must be notified at	급	10e. Street and Number	2015			10f. Zip C		000		, in	og. Onizeri or		nuy :			
	ns 23	eral	3219 NERAK I	12. Was Deceder		S. 13.	Was Decede		208 Ispanic Orig	gin? (Spec	cify Yes or No- Rican, etc.)		USA ce - Ameri				
9	or Iter	by Funeral	1 Never Married 2 Ma	Armed Forces arried 1 Tyes 2 T						i, Puerto F	Rican, etc.)		ick, White,				
93	ours (		XXWidowed 4 □ Divorce	ed Year or Dates	3:		1 ☐ Yes A	X	Specify:			Speci	W	HITE			
21215-0036	n 72 h "natu	Completed	15. Decede (Specify only high	ent's Education lest grade completed)		16a. Dece (Give	dent's Usual kind of work DO NOT use	Occupa done d	ation during most	t of workin	g	16b. Kind of E	lusiness/In	dustry			
12	within ene. than	g L	Elementary/Secondary (0-12)	College (1-4o	or 5+)		MEMAKE		/			OWN	HOME				
	filed Hygi ther ther	BeC	17. Father's Name (First, Middle	e, Last)		1101	100 103000		18. Mothe	r's Name	(First, Middle, M						
Maryland		O B	UNOBTAINABLE	C	AMPBEL	L			UN	OBTA:	INABLE	UNOI	BTAIN	ABLE			
lary	and and le rr		19a. Informant's Name/Relation	nship (Type, Print)							Route Number,			Code)			
	1 and 3 Health tem 27 other tr		LYNN LOBE/DAUG	HTER	20h Bi		MELOD sition (Name		ANE;		IMORE, N	1D 212		own State			
Baltimore,	Pages 1 all nent of Hea int: If Item iry or othe		20a. Method of Disposition  XX Burial 2 ☐ Cremation	1 3 □Removal from Stat	to CE	emetery, crei	matory or oth	er plac									
Ë	it. Pa intmen intent: njury	li	* 4 □ Donation 5 □ Other 21. Signature of Funeral Service		DEI		Name and		-		/2005 F						
Ba	permit. Pages Department of I Importent: If Its any injury or o once.		Edward	( Russ	C					001	LEVINS	KESVII	JE, 1	MD 21208			
			23a. Part1. Enter the disease, shock, or heart failure. Li	or complications that caus st only one cause on each	sed the death	. Do not en	er the mode	of dying	g, such as	cardiac or	respiratory arre	est,		Approximate Interval Between			
	Physician		Immediate Cause (Final disease or condition	CAFE	SIOPU	LINON.	ARY	FA	Mill	LE				Onset and Death			
	/Medical Examiner		Due to (or as a consequence of):									0					
	zxammer	_	Sequentially list conditions,	b. PNE	b. PNEMONIA Due to (or as a consequence of):												
	ted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	<b>3</b>	as a consequ	201100 017.											
<u>.</u>	be executed siclen and burial-transit	Exar	that initiated events resulting in death) Last	c	as a consequ	ence of):											
8760,	The law requires that the death certificate be executed the has been signed by the attending physicien and sage 2 should be detached for use as the burial-transit			d													
9	ntifica ng ph as th	Physiclan/Medical	IF FEMALE:				•										
Вох	leath certifica attending ph I for use as th	an/	23b. Was decedent pregnant  1 Live birth 2 Fetal death 3 Ectopic pregnancy								ate of delivery onth Day Year						
	the a	/sicl	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant 9□ Unknown		eath 5	Other (spec	cify)									
P.0	res that the de signed by the a be detached i	by				Part II. Other significant condi	tions contributing to death	but not resu	alting in the u	nderlying cau	use give	en in Part I.		23e. Did tob	acco use cor	tribute to t	he cause of death?
Vital Records,	uires signi ld be										1 □ Ye	s 2ZNo	3 🗆 Prot	oably 4 Unknown			
CO	w require been signature	lete									24a. Was ar	n 24b.	Were auto	ppsy findings available			
Be	The law sete has page 2 a	Completed						autopsy prior to completion of cause of death?				2 No					
ta		0	25. Was case referred to medic	cal					26. Place	of Death	(Check only one						
of V	d is	To B	examiner? 1 🗆 Yes 2 🗷 No	Hospital: Inpa	atient 2 🗆 I	ER/Outpatier	nt 3 DOA	Othe	er: 4 ☐ Nu		ne 5 🗆 Reside			(y)			
			27. Manner of Death 1. □ Natural 5 □ Pend	28a. Date of Ir (Month, L	njury Day Year)	28b. Time o Injury		c. Injury Work	k?		8d. Describe ho	w injury occu	rred				
<u>s</u>	ten leat lor: the	cat	2 Accident invest	stigation d not be mined 28e. Place of	Internet At Inc.	form at	M		Yes 2□		8f. Location (Street and Number or Rural Route Number,			al Route Number			
Division	in Signal	Certification:	4 Homicide dete	mined 289. Place of building,	etc. (Specify	()	eet, lactory,	OHICE			City or Town	, State)	00, 0, 1,0,				
	spital lours neral filled		29a. Certifier 1 Certify	ying Physician: To the be	st of my know	wiedge, deat	h occurred at	t the tim	ne, date an	id place, a	nd due to the ca	use(s) and m	anner as s	tated.			
	To the Hospital or At within 24 hours effer d To the Funeral Direct completely filled in by	edical	(Check only 2 Medic one)	al Examiner: On the basis and manner		tion and/or in	vestigation, i	in my op	pinion, dea	th occurre	d at the time, da	ate and place	and due to	o the cause(s)			
	To the To the Comp	×	29b. Signature and title of certification	ier			-		e number			9d. Date sign					
			Ex Dulyn	The same	W	·D.	AT	- 2	4380	946	-E13	MAY	,10	, 2005			
	V		30. Name and address of person						8.4				_				
	\		31. Date filed (Month, Day, Yea	SMANI 32. regis	strar's Signal	MST U	WIVER	Sir	4 4	KWY	1 /BAL	TIMOR	-E	MD 21213			
	Sta Registi		MAY	[3 2005]	strar's Signa	G A	person										

State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Ragistra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Year **Physician** 1003 CROMWEL 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner VA MEDICAL CENTER ALTIMORE Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1⊠M 2□ F Year 216-28-9892 Yrs. Director Uńknown Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City. Town or Location 10a. State 10b. Counts 10d, Inside City Limits Item 27 Ia marked other than "natural", or Items 23a or 28a-f ehow other traumatic event, It e Medical Examinar must be notified at Maryland Baltimore Baltimore 1 ☐ Yes 2 XNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5810 Reisterstown Road 21215 Completed by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2/☐ No Specify: White Specify: 3 ☐ Widowed 4 ☑ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Unknown Unknown Unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental h Unknown Unknown 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Veterans Affairs 3900 Loch Raven Blvd., Baltimore, MD 21218 Health Item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State May ō₩ 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. 2005 Maryland Veterans Cem Crownsville, Maryland ` 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stallings Funeral Home, P.A. 21. Signature of Funeral Se vice 3111 Mountain Road, Pasadena, MD 21122 ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ause on each line. 23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Pnysician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of) Examiner if any leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events Hospital or Attending Phyelclen: The law requires that the death certificate be executed use as the burial-transit resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 X No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 ☐ Yes 2 X No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the John Perkilus 29b. Signature and title of cert ION GREENE STREET BA 30. Nam and address of person we o completed cause of death (Item 23a) (Type, Print) IVA 31. Date filed (Month, Day, Year) State Eleve & Specie Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2005 Year Physician May 12, Raj Kumar Chopra 6:10 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral 9. Birthplace (State or Foreign Months 1 🛣 M 2 🗆 F 219-90-0044 Yrs Director 71 Sept. 23, 1933 India Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heath and Mental Hyglene.
ant: If item 27 is marked other than "natural", or iteme 23a or 28a-f ehow ury or other transmit. In the Medical Examination and the invilled at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Completed by Funeral Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1123 Netherlands Court 20905 India 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: Asian-Indian 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant World Bank 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jagdish Narayan Chopra Gauran Devi ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phool Chopra/Wife 1123 Netherlands Ct., Silver Spring, Maryland 20905 20b. Place of Disposition (Name of Cometery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of P Important: If ite any injury or of once. 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State May 13, \* 4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland Crematorium, Inc. Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Ave., Bethesda, MD 20814-3501 21. Signature of Funeral Service Vicensee M00198 23a. Part1. Enter he disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of); Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death signed by the at t be detached for 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 XNO 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 1 Yes director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Inpatient 1 Tes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3□ DOA funeral 27. Manner of Death Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of After Injury 5 Pending after death. Diractor: A 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral I A certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D36980 80 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15 344 University Blvd. West, Silver Spring, Maryland 20901 Satish Angra, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

			State of Manuand / F	Department of Health and Mental Hy	3
			01-4	Certificate of Death	Reg. No. 2005 16208
	Physic	ian	1. Decedent's Name (First, Middle, Last)	2. Date of D Month	G. Fillio G. Doddi
	/Medi	cal	GERALD LOOPITS COM	110>	11 2005 9 9M
	Examir	ner		4b. City, Town, or Location of Death  Rockville	4c. County of Death Montgomery
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last bin	rthday) If Under 1 Year   If Under 24 Hrs.   8. Date of Bi	irth 9 Birthplace (State or Foreign
Ŀ	Director		336-22-2296 1 <sup>™</sup> M 2□ F 75  Usual Residence of Decedent	Months   Days   Hours   Min   (Month. D	Country) 2, 1929 Illinois
	yland Now		10a. State 10b. County 10c. City, Town	n or Location	10d. Inside City Limits
	e Man a-f sh liffed	ctor	Maryland Montgomery Wheato	on	1 □ Yes 21 No
	with th	Director	10e. Street and Number 12215 Midd1e Road	10f. Zip Code 20906	10g. Citizen of What Country? United States
	death ms 2;	Funeral	11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Specify Yes or Ni If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	
39	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or Itams 23a or 28a-f show any injury or other traumatic event. It is Medical Examiner must be notified at ance.	by Fur		If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 ☐ Yes 2 ☒ No Specify:	Black, White, etc.  Specify: White
21215-0036	72 hor	sted	15. Decedent's Education (Specify only highest grade completed)	Decedent's Usual Occupation	16b. Kind of Business/Industry
121	within ene. than "	To Be Completed	Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during most of working life. DO NOT use retired)	
	filed v Hygie sther t		17. Father's Name (First, Middle, Last)	alth Physicist  18. Mother's Name (First, Middle	Federal Government
au	ld be ental ked o		Claude Combs	Esther Loomis	o, Maiden Sumame)
Maryland	shou and M s mar	-	19a. Informant's Name/Relationship (Type, Print) 19b.	. Mailing Address (Street and Number or Rural Route Numb	per, City or Town, State, Zip Code)
	and 2 ealth a m 27 i			436 Narcissus Way, Rockvill	e, Maryland 20853
Baltimore,	Pages 1 nent of H ant: If ite			f Disposition (Name of place)  Date place)	20c. Location - City or Town, State
Ē	artmer artmer ortant injury		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licensee	f Heaven Cem. May 14, 2005  22. Name and Address of Facility Robert A.	Silver Spring, Marylan
Ba	permit. Departr Importa any inja		M00198	Rockville, Inc., 300 West Rockville, Maryland 20850-	Montgomery Avenue,
П			23a. Part1. Exter the disease, or complications that caused the death. Do n shock, or heart failure. List only one cause on each line.	not enter the mode of dying, such as cardiac or respiratory a	trrest, Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)  a. RESPIRATOR	4 HYPOXIA WITH AR	REST 46HRS
	/Medical Examiner		Due to (or as a consequence of	11 0	11.10 71000
P		Jer	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of	We hung ANCER 1)	NASIUC 1CIA95
V	te be exacuted ysician and ie burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	LCELL LUNG CANCEN	R Metastatic 5 MOD
760,	be execian a	cal Ex	resulting in death) Last  Due to (or as a consequence of		
687			d. WILL N SWC	1 Stage KENAL DINER	se syrs
ŏ	h certi ending	M/W	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death	2054	23d. Date of delivery
Ö	Tha law requiras that the death certifica te has been signed by the attending ph bage 2 should be detached for use as th	Physician/Med	in the past 12 months?  1  Yes 2 No 9  Unknown  1  Unknown	3 Ectopic pregnancy 5 Other (specify)	Month Day Year
٥.	that the poly detail	y Ph	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I. 23e. Did t	obacco use contribute to the cause of death?
Records,	equiras en sign	ed by	DELIGIBLETTUS	lectrolyte 1x	Yes 2 No 3 Probably 4 Unknown
ecc	law re	Completed	IMBALANCE-HUPOG	Lycania , 24a. Was autor	
_		Con	with DRUG In LURE	ED LEUKOPENIA 10 yes	ormed? death? 1 Yes 2 No
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?  Hospital:	26. Place of Death (Check only of Other:	
ō	iding Phys th. After this funeral di	n: To	27. Manner of Death 28a. Date of Injury 28b. Ti	tpatient 3 DOA 4 Nursing Home 5 Hesi	dence 6 ☐Other (Specify) how injury occurred
ion	Attending Physician: It death. sctor: After this certifica by the funeral director.	atlo		ime of piury M 28c. Injury at Work? 28d. Describe I	
Division of	F in C	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	rm, street, factory, office 28f. Location (5 City or Tow	Street and Number or Rural Route Number, wn, State)
	Hospital or 24 hours afte Funeral Dir tely filled in		29a. Certifier 157 Certifying Physician: To the bast of my knowledge		
	To the Hospital of within 24 hours af To the Funeral D completely filled in	edical	(Check only one)  2 Medical Examiner: On the basis of examination and and manner stated.	, death occurred at the time, date and place, and due to the d/or investigation, in my opinion, death occurred at the time,	cause(s) and manner as stated. date and place, and due to the cause(s)
	To the within 2 To the complet	M	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
			HONN & SNIGO, MIL	) NOS10+	05 12 2005
	1+8		John J. Shigo, MD 18540 Office Park	Type Print)  Drive, Montgomery Village,	, Maryland 20886-0586
	Sta Registra		31. Date filed (Month, Day, Year)  32. Regitrar's Signature	books	

1- State of Maryland / Department of Health and Mental Hygiene 2  Certificate of Death  Reg. No.							4 U	05	16209								
	Physic	ian	1. Decedent's Name (First, Middle, E			2. Date of Dea	ath	Year	3. Time of Death								
	/Medi	ical	HOWARD		ASSIN	MAY 11	, 2005		12:15 A M								
	Exami	ner	4a. Facility Name (If not institution, g HOSPICE OF BALT	•	RIST CTR. 4b. City, Town, or Location of Death				-	BALTIMORE							
	Funeral			Sex 7. Age	(In yrs. last birthday)	If Under 1 Year	If Under 24 Hr	s. 8. Date of Birt	h		ORE ce (State or Foreign						
L	Director		216-56-5019	1 M 2 □ F	53 Yrs.	Months Days	Hours Mir	SEPT. I	8,1951	Country	MD						
	land w		Usual Residence of Decedent  10a. State 10b. County		IOc. City, Town or Lo	cation				10d	. Inside City Limits						
	Mary -faho	tor	MD BAL	TIMORE		IMORE					1 ☐ Yes 2 ☑ No						
	death with the Maryland ms 23e or 28e-f ahow	Funeral Director	10e. Street and Number	TITIONE	DALI	10f. Zip Code			10g. Citizen of W	hat Country							
	23e c	a D	8812 JOSHUA CO	URT			21208				USA						
	tams	nue	11. Marital Status	12. Was Decedent Ev Armed Forces?		Was Decedent of H	Hispanic Origin? ( an, Mexican, Pue	Specify Yes or No- into Rican, etc.)	14. Race Black	- American , White, etc							
36	irs aft	by F	1 ☐ Never Married 2 💢 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 No If Yes, Give Year or Dates:		I□Yes 2∏X No	Specify:		Specify:		WHITE						
21215-0036	72 hours after natural; or Ita		15. Decedent's	Education		lent's Usual Occup			16b. Kind of Bus								
215	within 7 ene. then "n	Completed	(Specify only highest g Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	kind of work done OO NOT use retire	during most of w d)	orking			,						
	iled willed will will will will will will will wil	S	17. Fatharia Nava (First Middle 1	5+	ATTO	RNEY			LAW								
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked othar then "natural", or Itams 23e or 28a-f ahow amy injury or othar traumatic evant, If a Moulcal Examiner must be notified at ADRS.	To Be	17. Father's Name (First, Middle, Las	5()	CASS	T N	18. Mother's Na	ame (First, Middle,	Maiden Sumame		LAZARUS						
ary	and M s mar	-	19a. Informant's Name/Relationship	(Type, Print)				Rural Route Numbe	r, City or Town, S								
	and 2 ealth a n 27 is		SUSAN CASSIN /	WIFE			COURT -	BALTIMOR	E, MD 21	208							
Ore	ges 1 t of Ho If itan or oth		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3	☐Removal from State		natory or other plac	·	Date	20c. Location - C	ity or Town	, State						
Baltimore,	t. Partmen		`4 □ Donation 5 □ Other (Spec	cify)	BALTIMORE			-	REISTER		<u> </u>						
Ва	permit. Departr Imports any inju		21. Signature of Funeral Service Lice	prisee HHA		Name and Addre	9	OL LEVINS									
	Physician /Medical Examiner		23a. Part1. Enter the disease, or con	mplications that caused th	e death. Do not ente	er the mode of dyir	ng, such as cardia	ROAD - I	rest,	Ar	oproximate						
			shock, or heart failure. List onl Immediate Cause (Final disease or condition	y one cause on sch line.	untro	ohiz L	stood	Schei	2200		terval Between nset and Death						
			resulting in death)	a Due to (or as a c	sequence of):	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Marke	-000	10 31 3	-	Jesus						
		_	Sequentially list conditions,	b. Due to (or as a consequence of):													
b		niner	Sequentially list conditions, I any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events														
7	execu n and ial-tra	Examin	that initiated events resulting in death) Last	c. Due to (or as a c	consequence of):												
8760,	icate be executed physician and s the burial-transit	dlcal	•	d													
9	artifica ing ph e as th	0	IF FEMALE:	714.													
Вох	feath certifica attending ph for use as the	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth 2 [	Fetal death 3	Ectopic pregnancy	,		23d. Date Month	-	v Year						
0	the check	Physiclan/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at tin 9□Unknown	ne of death 5 □	Other (specify)			I WOILE	, Da	y real						
0	s that the need by a detac	Completed by Ph							Part II. Other significant conditions	contributing to death but r	not resulting in the un	derlying cause giv	en in Part I.	23e. Did to	bacco use contrib	ute to the c	ause of death?
Records,	w requires been sign should be							1 🗆 Y	es 2 No 3	☐ Probably	y 4 ∐Unknown						
900	e law requ has been je 2 shouli							24a. Was a	n 24b. We	re autopsy	findings available etion of cause of						
Ä		Com						autops perform	ned? dea	or to comple ath? ]Yes 2[							
Vital	Physician: Th this certificate al director, paç	Be	25. Was case referred to medical examiner?	Hamitah		Lau		ath (Check only on			-1						
of	Phys r this ral dii	<u>ا</u>	1 Yes 2 No  27. Manner of Death	Hospital: 1 ☐ Inpatient 28a. Date of Injury	2 ER/Outpatient	3 DOA Oth	4 [] Nulsing i	Home 5 Reside	-	Y	tospio						
on	nding Pt th. : After th s funeral	tlon	1 Natural 5 Pending Investigation	(Month, Day Y	ear) Injury	Wor	yat k? Yes 2 □ No	28d. Describe no	ow injury occurred								
Division	l or Attandir after death. Diractor: Ai in by the fu	Certification:	3 Suicide 6 Could not determined	be 28e. Place of Injury	- At home, farm, stre			28f. Location (St	reet and Number	or Rural Ro	oute Number,						
O	ital or A rs after rel Dirac led in by	Cert	T I TOMBOO	building, etc. (	эреспу)			City or Town	n, State)								
	To the Hospital or Attanding within 24 hours after death.  To tha Funarel Diractor: After completely filled in by the fune	edical	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysicien: To the best of n miner: On the basis of ex and manner stated	amination and/or inv	estigation, in my o	pinion, death occ	urred at the time, d	ate and place, and	d due to the	cause(s)						
\	To the within 2. To the complet	Σ	29b. Signature and title of certifier	1 10		29c. License	e number	2	9d. Date signed (	Month, Day	( Year)						
,	0-		171 Hotel	roy Mile	2 mis	1)2	2 302	/	MAYL	1,20	205						
	1		30. Name and address of person who	completed cause of deat	(Item 23a) (Type, F GBMC Signature	6701	N.C	harles	St Be	lto.	M2 2120x						
•	Sta Registr	1.7	31. Date filed (Month, Day, Year) MAY 1	3 2005 Negistar's	Signature St.	Gode											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No.-2. Date of Death 1. Decedent's Name (First, Middle, Last) Manth **Physician** 119 Walter 12:00AM 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner NURSING ARMACOST DALTI MORE If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Birthplace (State or Foreign **Funeral** YearL 100 M 2□ F Days 220:14:453 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10a State 10d. Inside City Limits or 28e-f show other traumatic event, the Medical Examiner must be notified at 1 **1**Yes 2 □ No BAUTIMORE Director MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or items 23e 2220 Completed by Funeral 14. Race - American Indian, Black, White, etc. ispanic Origin? (Specify Yes or No-an, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status Armed Forces Specify: BLACK 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Yes, Give 'ear or Dates: 1 Yes 2 No Specify 3 Widowed 4 Divorced "neturai", 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maigen Sumame) 17. Father's Name (First, Middle, Last) Be ould be 1 DIGGS 2 19b. Mailing Address (Street and Nymber or Rural Route Number, City

HOS LOCH KAVEN BUD. (SISTER) ACTIMORE, MOZIZZ ANCHE Method of Disposition

1 🖾 Burial 2 🗆 Cremation 3 🗀 Removal from State 9 any injury o ` 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Approximate Interval Between Onset and Death 23a. Part 1. 5 her the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** arcinoma /Medical Examiner 10915 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The taw requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 □Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 第Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 🏋 No 24a Was an autopsy rmed? 2.2 No 1 Yes Attending Physician: filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner's 1 Yes 2 No 1 Inpatient Certification: To 2 ☐ ER/Outpatient 3□ DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after death To the Funeral Director: 6 Could not be determined 3 🗋 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ō 29a. Certifier 1 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai completely (Check only one) 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier lacem MD

Registrar

DHMH 17 Rev 1/2001

501 Dol

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2005

AMATU N

NAEEM

32. Registrar's Signature

Registrar

amend item#4a, perMD, G843, 5/13/05 IT
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Wanda E. Draper 2 5:20 P 2005 May /Medical 4a. Facility Name (If not introduced in the street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Joseph Bitchey Hospice Baltimore
If Under 1 Year | If Under 24 Hrs. 8. Date of Birth

Jan. 7, 1965 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Maryland Months Days Hours 1 □ M 💥 🗆 F 40 Director 216-86-4424 Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show other traumatic event, the Medical Examiner must be notified at Maryland N/ABaltimore 1X Yes 2 □ No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō USA 21215 3842 Reisterstown Road or Items 23a death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc 1 X Never Married 2 Married Black 1 ☐ Yes 2 ☐ No Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housekeeper BWI Airport 8th grade 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Glenis Lee Leon A. Draper 19b. Mailing Address (Street and Number or Rural Route Number & City or Town, State, Zip Code) 402 N. Aisquith St. Baltimore. Md 19a. Informant's Name/Relationship (Type, Print) Glenis Draper/ Mother Baltimore, Md 21202 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 5/9985 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Dundalk, Maryland Voshell Memorial Gardens ^ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of Funeral Service Licensee 5240 Reisterstown Rd Baltimore, Md 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician try viced immune /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine requires that the death certificate be executed ed by the attending physicien and detached for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 2 No Month Year Day 5 Other (specify) 4□Pregnant at time of death 9 DUnknown cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate has 1 ☐ Yes the Hospital or Attanding Physician: After this certific funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 27. Manner of Death 28b. Time of 1 ANatural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funaral Director: A 2 Accident investigation 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and oue to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of ray knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 7 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NEutaw St Baltimore MD 838 E. ISO MO hen Hospice State Registrar

		•	State of Maryland / Department of Health and  1- State Registrar  Certificate of Death	Mental Hy	giene 200	5 16213
			Decedent's Name (First, Middle, Last)	2. Date of De	eath	3. Time of Death
	Physicia		David A. Dixon	Month 05	Day Yea	5 00: 56 AM
	/Medio Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Deat		4c. County of De	
			Union Memorial Hospital Bultimore			
	Funeral		5. Social Security Number 6. Sex 1 M 2 F 7. Ade (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Months Days Hours Min.	8. Date of Bir	rth ay, Year)	Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent	14-20	1-29 M	4KYLANLS
	land ow		10a. State 10b. County 10c. City, Town or Location			10d, Inside City Limits
	Man Ffsh	ţō	MD BALTIMORE			1 Yes 2 □ No
	r 288	Director	10e. Street and Number 10f. Zip Code		10g. Citizen of What	Country?
	23a c		3206 N Calvert St. 21218		US	SA
	r dea	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (S	Specify Yes or No to Rican, etc.)	o- 14. Race - Ar Black, W	merican Indian, hite, etc.
36	s afte	by F	1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 Yes 2 No Specify: Year or Dates:		Specify: /	16:10
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212	d with giene.	ĕ	5 General Laborer		Maintai	reice.
	be filed tal Hygid d othar svant, III	Be (	17. Father's Name (First, Middle, Last)  18. Mother's Nam	me (First, Middle	, Maiden Sumame)	
yla	2 should be filed and Mental Hygi is markad othar aumatic svant,	ဥ		Joseph	ine Beh	00
Maryland	2 short and is m		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rel			
	ges 1 and 2 should be filed within 72 hours after death with the Marylan It of Heath and Mental Hygiene. If itam 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic svent, the Marical Examinating at the nulliked at		14(CCC JC Haas) Sister 30(C V. Calvert St.) 20a. Method of Disposition 20b. Place of Disposition (Name of	DHLTI	MORE M 20c. Location - City	or Town State
Baltimore,	pernit. Pages 1 and Department of Health Important: If itam 27 any njury or othar tr onca.		cemetery, crematory or other place)			0.0
臣	permit. Pag Department Important: I any injury o		1. Signatur, of Funeral Service License 22. Nam and Address of racility 1. 1. 1. Nam and Address of racility 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1.	16-00	Timon.	m Me
Ba	permit. Departr Importa		2325 YORK P.D.	TIMON:	on MD 210	TONCENTER.
			23a. Part1. Enter the disease, a complications that caused the death. Do not enter the mode of dying, such as cardial shock, or heart failure. List only one cause on each line.	c or respiratory a	arrest,	Approximate Interval Between
	nysician		Immediate Cause (Final disease or condition Respiratory failure			Onset and Death
	/Medical		resulting in death)  Due to (or as a consequence of):			TVIK
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	sit ad	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
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9	ificate g phy as the	edic	0.			П
Вох	death certific attending plant of for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 1		23d. Date of	*
	ne deat the attr hed for	sicis	1 Yes 2 No 4 Pregnant at time of death 5 Other (specify)		Month	Day Year
P.0	that the de ed by the detached	Phy	9 Unknown	00- Bid		
	signed be det	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			e to the cause of death?  Probably 4 ***QUnknown
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o	g Phys er this eral di		27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at		how injury occurred	poorty
io	Attanding F r death. actor: After by the funer	atio	2 Accident investigation M 1 Yes 2 No			
Division	l or Attano after death Diractor: J in by the	Certification;	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		(Street and Number or wn, State)	Rural Route Number,
	urs aff			\		
	To the Hospital or Attanding Physician: within 24 hours after death. To the Funaral Diractor: After this certific completely filled in by the funeral director.	Medical	29a. Certifier  (Check only one)  Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place (Check only one)  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place (Check only one)	e, and due to the urred at the time,	cause(s) and manner date and place, and d	as stated. Jue to the cause(s)
	o the ithin o the omple	Med	29b. Signature and title of certifier 29c. License number		29d. Date signed (Mo	onth, Day, Year)
	⊢ s⊢ ŏ		Machikanijing On Call Physician D0053652		05-12-20	05
•	1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			
			RADHIKA VIJ. M.B. 201 E. University Parkney bal	itimore	MD 5151	8
	Sta		31. Date filed (Month, Day, Year) MAY 1 3 2005			
	Registi	air	WINI TO FOOD		/	_

		State of Maryla			•	9
		1 _ State		rtificate of Dea		2005 10011
		Registrar  1. Decedent's Name (First, Middle, Last)		inoate of bea	2. Date of I	
Phys		Tuy Dang			Month	8, 2005 Year 5:15 p M
Exam	dical niner	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Locati		4c. County of Death
		Mariner Health of Catonsv	ille	Catonsvi	lle	Baltimore
Funera		4(1)	. last birthday)	If Under 1 Year If Under 1 Year House	der 24 Hrs. 8. Date of 8 (Month, 1	Day, Year) Country)
Directo	or	220-41-8664 <sup>1</sup> ∑ <sup>M</sup> <sup>2</sup> □ F 74	Yrs.		Dec.	
land		Usual Residence of Decedent           10a. State         10b. County         10c. C	ity, Town or Lo	cation		10d. Inside City Limits
Mary -f sh	ţ	Md. Baltimore	Arbut	แร		1 ☐ Yes 21⁄2 No
n the	Director	10e. Street and Number		10f. Zip Code		10g. Citizen of What Country?
h witi	a D	1131 Gloria Avenue		21227		USA
ams	Funeral	11. Marital Status 12. Was Decedent Ever in t Armed Forces?	J.S. 13.	Was Decedent of Hispanic f Yes, specify Cuban, Mex	Origin? (Specify Yes or I	
36 after	- F	1 Never Married 2 Married 1 Yes 2 No		1 ☐ Yes 2 【 No Spec		Specify: White
hours turnal:	ed by	3 Widowed 4 Divorced Year or Dates:	162 Dogg	dent's Usual Occupation		Balling of Assessment Control
157 in 72	Completed	(Specify only highest grade completed)	(Give	kind of work done during r DO NOT use retired)	most of working	16b. Kind of Business/Industry
212 J with Jiene.	E	Elementary/Secondary (0-12) College (1-4or 5+) Unknown	Nur	sing Assis	tant	Health Care
e file otha vant,	BeC	17. Father's Name (First, Middle, Last)			other's Name (First, Mido	
yland 21215-0036  Juld be filed within 72 hours after death with the Maryland Mental Hygiene.  arkad othar than "natural", or Itams 23a or 28a-1 show atte awant, the Modical Examine the notified at	10	Lien Dang		U	nknown	
Maryland 21215-0036 d 2 should be filed within 72 hours at th and Mental Hygiene. 71's markad othat than "natural", or traumatic avant, tre Mudical Exami		19a. Informant's Name/Relationship (Type, Print)				nber, City or Town, State, Zip Code)
and and martr		Hoa Dang / Son				Mills, Maryland
Ges 1 tof H rite or otl		Dunal 2 XICremation 3   Removal from State		sition (Name of natory or other place)	Date	20c. Location - City or Town, State
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Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-1 show any injury or other traumatic avent, the Mudical Examines must be multified at	buce	21 Signature of Funeral Service Licensee	Elec-	. Name and Address of Fa	IIubbaiu	Funeral Home, Inc.
		23a. Part1. Enter the disease, or complications that caused the dea shock, or heart failure. List only one cause on each line.	th. Do not en	IU / WILKENS er the mode of dying, such	s Ave. Bal	timore, Md. 21229 Approximate
Dhusisis		Immediate Cause (Final		11.		Interval Between Onset and Death
Physicia /Medica	al	disease or condition resulting in death)  a  Due to (or as a condition)	quence of):	my or	huran	~
Examine	er		14	. choker	1	
D #	ne.	Sequentially list conditions, if any leading 15 immediate cause. Enter Undertying Cause (Disease or injury	Manager L	ghokes	1 1	
ecuter and -trans	Examiner	that initiated events	ser	mul of	troorder	
cords, P.O. Box 68760, requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	cal E	resulting in death) Last Due to (or as a conse	quence oi):	· ·		
687 ificate g phys as the		d				
Box ( Bath certil attending for use a	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnant				23d. Date of delivery
death death e atte	Icla	in the past 12 months?  1 Ves 2 No.  4 Pregnant at time of		Ectopic pregnancy Other (specify)		Month Day Year
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S, I es that igned be de	by	Part II. Other significant conditions contributing to death but not re	sulting in the u	nderlying cause given in Pa		d tobacco use contribute to the cause of death?
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25 8	nple	-	<del></del>		24a. We	topsy prior to completion of cause of
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Vision of Vital Records, P.O. Box 68 Attanding Physician: The law requires that the death certifical ar death. actor: After this certificate has been signed by the attending phy by the funeral director, page 2 should be detached for use as th	Be	25. Was case referred to medical examiner?  Hospital:	7	Othor	lace of Death (Check only	
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lon Inding Ith. :: Afte	ation	1 Natural 5 Pending (Month, Day Year) 2 Accident investigation	Injury	Work? M 1 ☐ Yes 2	2 □ No	
Division of tor Attanding Phy after death.  Diractor: After this in by the funeral d	III	3 Suicide 6 Could not be determined 28e. Place of Injury - At he building, etc. (Spec	nome, farm, sti	eet, factory, office		n (Street and Number or Rural Route Number, Fown, State)
Di tal or rs afte al Dir	Certification:	Sulfairing, Ste. (opper			0.1, 6	own, outloy
Division of Vital Re To the Hospital or Attanding Physician: The I within 24 hours after death. To the Funeral Diractor: After this certificate ha completely filled in by the funeral director, page		29a. Certifier (Check only Medical Examiner: On the basis of examin	owledge, deat ation and/or in	n occurred at the time, date	e and place, and due to the death occurred at the time	ne cause(s) and manner as stated. e, date and place, and due to the cause(s)
To the h within 24 To the F complete	Medical	one) and manner stated.  29b. Signature and title of certifier		29c. License numb		
To with	-	29b. Signature/and title of centries	1.	29C. License Humb	0 210	29d. Date signed (Month, Day, Year)
		30. Name and address of person who completed cause of death ate	m 23a) (Type,	m 1)2	7 169	11400
le	)	WAYES LAST D. While and address of person will complete datase of death file	200 (Type,	w) [/4	N. 10.11.	bl Buldila 12/28
	State	31. Date filed (Month. Day, Year) 32. Registrar's Sign	ature	, , , ,	- welly	17 TOWN
Regi	strar	MAY 1 3 2005	1. A	rest		
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			ORIGINA	AL.		

State of Maryland / Department of Health and Mental Hygiene [ ] [ 5 For State Registrar amend item #5 per fh 8845 7/06/05 JH 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) MAY **Physician** 2005 4:15P DANSICKER **HERBERT** /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** BALTIMORE OWINGS MILLS 126 HARRY LANE APT. #C Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 05/25/1922 7. Age (In yrs. last birthday) **Funeral** Days Months Hours MD 82 Director Usual Residence of Decedent Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County ral, or items 23s or 28s-f show Examiner must be notified at 1 ☐ Yes 2 No **Funeral Directo** OWINGS MILLS MD BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe U.S.A. 126 HARRY LANE APT. #C 21117 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 N Yes 2 No Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 10 WHITE 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify. If Yes, Give Year or Dates: Completed by 3 Widowed 4 Divorced "natural" the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry atal Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) TOWING **PROPRIETOR** 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Ith and Mental F 27 Is marked of r traumatic even VOGEL DANSICKER SARAH BENJAMIN ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) nt of Health a t: If Item 27 Is nor other tra OWINGS MILLS, MD 21117 126 HARRY LANE APT. #C IRENE BETTY DANSICKER / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. REISTERSTOWN, MD OHEB SHALOM MEMORIAL 05/11/2005 \* 4 □ Donation 5 □ Other (Specify) e Licen 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signa 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest Part1. Enter the disease, or complications the shock, or heart failure. List only one cause Immediate Cause (Final Physician MNITHS /Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and Due to (or as a consequence of) P.O. Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death Month Year Day in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, à 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Tyes 1 🗌 Yes 2 🗆 No certificate 2**)** No or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home Mesidence 6 Other (Specify) 1 Inpatient 1 🗌 Yes 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1 Satural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation the within 24 hours after deat To the Funerel Director: completely filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and DOD 1931 no completed cause of death (Item 23a) (Type, Print) GREENETRRE RD BAKT 32. Pagistrar's Signature 31. Date filed (Month, Day, Year) State Registrar

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JAMES

			1 - For Amend Item 2	State of Maryland Oa per fh G843	d / Department of 5-13-05 tas	Health and M Death	ental Hygiene	2005	16217
	Dhuaisi		1. Decedent's Name (First, Middle, Las				2. Date of Death Month, Da		3. Time of Death
	Physici /Medic		Harold Eru	ochalu			May 9	Z OCO 5	4:54 PM
	Examin	er	4a. Facility Name (If not institution, give		4b. City, Town,	or Location of Death		County of Death	
	Funeral		5. Social Security Number 6. Se					Be. FIMD	place (State or Foreign
П	Director			ZM 20 F 54	Yrs. Months Days	Hours Min.	8. Date of Birth (Month, Day, Year)	1950 A	liceria
	and w		Usual Residence of Decedent  10a. State 10b. County	10c City	, Town or Location		VOICE INC.		10d. Inside City Limits
	Maryit f sho	ō	2 1	more Pe	erruball				1 Yes 2 □ No
	r 28a	irec	10e. Street and Number		10f. Zip Code		10g. Cit	izen of What Cou	intry?
	23a c	aD	8 Wra GBY	Ct.	21	128	1	Viger	10
	er dea Items Der m	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	S. 13. Was Decedent of If Yes, specify Cut	Hispanic Origin? (Spe can, Mexican, Puerto I	cify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
39	urs aft		1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No	Specify:		Specify: B	ack
21215-0036	filed within 72 hours atter death with the Maryland Hyglene. ther than "natural", or tlems 23a or 28a-f show int, tha Madical Eraminat must be notified at	Completed by	15. Decedent's Ed (Specify only highest grad		16a. Decedent's Usual Occu (Give kind of work done	pation	16b. K	ind of Business/Ir	ndustry
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ary	2 shou and A is mai	- 18	19a. Informant's Name/ elationship (T		19b. Mailing Address (Stree	t and Number or Rura	l Route Number, City o	r Town, State, Zi	o Code)
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<u>ا</u>	iges 1 nt of H : If ite or ot		20a. Method of Disposition  1 Burial 2 Cremation 3 1	Removal from State	ace of Disposition (Name of emetery, crematory or other pla		2	ocation - City or T	
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other Once	1	*4 ☐ Donation 5 ♣ Other (Specify, 21. Signature of Fune vi 5 ♣ Licens			i	IS CHAPEL	OBI, AN	DAMBADA
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œ .	that the death cer ed by the attendir detached for use	sicla	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown		:y 		Month	Day Year
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CO	w require been si should I	lete					24a. Was an		ppsy findings available
	The law cate has page 2 s	Completed					autopsy performed?	prior to co death? 1 \( \sum \text{Yes}	mpletion of cause of
Division of Vital	yaician: Th	BeC	25. Was case referred to medical examiner?			26. Place of Death	1 ☐ Yes 2 ☑ No Check onlone	1 LI Tes	2 5 NO
2	hyaic this ce al dire	P.	1 ☐ Yes 2 No		-Prodipatient 3 DOA		ne 5 🗌 Residence (		(y)
ou	ding F h. After funera	tlon:	27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)		ryat 2 rk? ]Yes 2 ∐No	8d. Describe how injur	y occurred	
<u>s</u>	Attendir death.	ifica	3 Suicide 6 Could not be	286. Place of injury - At nor	me, farm, street, factory, office		8f. Location (Street and	d Number or Rura	al Route Number,
ā	s afte	Certification:	4 Homicide determined	building, etc. (Specify)	)		City or Town, State,	)	
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	Check billy 2 Medical Exam	sician: To the best of my know iner: On the basis of examinati	vledge, death occurred at the ti	me, date and place, a opinion, death occurre	nd due to the cause(s) d at the time, date and	and manner as s	tated.
	o the ithin 2 o the omplet	Med	one) 29b. Signature and title of certifier	and manner stated.	29c. Licen	se number	29d. Date	e signed (Month,	
	ÿ → ₹ →		1 1	19	AUY	17643571	5854 5	19/05	,,,
	(1		30. Name and address of person who o	ompleted cause of death (Item:	23e) (Type, Print)		,	/ /	<u> </u>
	VI		Mark To	VIÃO 22 5.	Grane ST.	Unis No	179701 (C	cu)	
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_			State of Maryland / Department of Health and Maryland / Department of Health / Department of Health / Department of Health / Department / D	Reg.	2005	16218
	Physici /Medio		1. Decedent's Name (First, Middle, Last)  Charles K. Fisher	2. Date of Death APRIL20,	<sup>Day</sup> 2005 Year	3. Time of Death 6:28 P M
	Examir		4a. Facility Name (If not institution, give street and number)  REAR OF 605 PLOY ST  4b. City, Town, or Location of Death BALTIMORE CITY		4c. County of Death	
7285	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.  Usual Residence of Decedent	8. Date of Birth (Month, Day, Ye, Aug. 30, 19	9. Birthpl 63 Ma	lace (State or Foreign try) ryland
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	death w	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specific Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - America	
920	urs after al', or Ita	þ	Armed Forces?  1 Never Married 2 Married 1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto 1 Yes 2 No If Yes, Specify:  1 Yes 2 No	nican, etc.)	Black, White, &	ack
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Maryland 21215-0036	ould be Mental larked o	To Be	unk	(1 113t, Middle, Maid	en Sumame)	unk
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If itam 27 is marked othar than "natural", or Itams 23e or 28a-f ahow any injury or other traumatic avant, the Marical Examiner must be notified at once.		19a. Informant's Name/Relationship (Type, Print) (Social)  MS. Dawn Freer Worker 420 Print OSE A	Ve PaH	or Town, State, Zip	Code) 1d. 21215
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Baltii	permit. F Departme Importar any injur		21. Signatore of Funeral Service Licensee  22. Name and Address of Facility  23. Name and Address of Facility	Sinoval	Home P.A	yria.
			23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac o shock or heart failure. List only one cause on each line.	r respiratory arrest,	ld. 21216	Approximate Interval Between
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J	To the Hospital or Attanding Physician: The within 24 hours after death.  To the Funaral Diractor: After this certificate his completely filled in by the funeral director, page	edical Ce	29a. Certifier  (Check only  (Check only  (Check only)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred.	Baltimore, and due to the cause and at the time, date a	s) and manner as sta	ted.
	To the l within 2. To the I complet	Med	one) and manner stated.  29b. Signature and title of certifier 29c. License number	29d. D	ate signed (Month, D	lay, Year)
			30. Name, and address of person who completed cause of death of tem 23a) (Type, Print)	AP	RIL 21, 20	05
	U	10	THE UND RE LUICING 111 Penn Street 31. Date filed (Month, Day, Year) 32. Postrar's Signature	et Baltim	ore, Maryl	and 21201
	Sta Registr		MAY 1 3 2005 Seem & Speed			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 29d per dvr 88/3 5-13-05 vt.
State of Maryland Department of Health and Mental Hygiene
amend item/5, perFH, G843, 5/16/05 TT

Beg. No. 0 5 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** MARLE. 05 05 1:30 PM C /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BACTIMORE BACTIMORE IKE If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 746 6. Sex 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 M 2 □ F Yrs. 55 Director 11-10-1949 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a State 10d. Inside City Limits 28a-f ehow drer river be notified at 1 XYes 2 No NA Directo MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5110 BALTIMORE NATIONAL PIKE 21229 Items 23a USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ Specify: BLACK 1 ☐ Yes 2 K No ۵ Specify: other traumatic event, the Mudical Exam 3 Widowed 4 Divorced "netural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7: th and Mental Hygiene. 7 is marked other than "n. Elementary/Secondary (0-12) College (1-4or 5+) CLEANING LABORER 10 TH GRADE NA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) CHARLES GREEN. PEARL MARINE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Nymber or Rural Route Number, City or Town, State, Zip Code) 121 N. MONASTERY AVE., BALTO. MD permit. Pages 1 and 2 Deportment of Health a Important: If item 27 is any injury or other tra CHARLES GREEN 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ⊠Burial 2 □ Cremation 3 □ Removal from State 05.4.05 BALTIMORE, MD ARBUTUS \* 4 ☐ Donation 5 ☐ Other (Specify) VAUGHN C. GREENE FUNERAL SERVICE 5151 BAUD. NATU PIKE, BAUD. MD 21. Signature of Funeral Service Licensee an 21229 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head ailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician ), AUGETES /Medical Due to (or as a consequence of): Examiner HEON C) Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury for as a consequence off Examine use as the burial-transit COHOL that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has 2 No 1 ☐ Yes the funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 sesidence 6 Other (Specify) 1 ☐ Yes 2 📉 Vo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA his 27. Mapper of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred e Hospital or Attending P 24 hours after death. e Funeral Director: After the Certification: Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) To the Within 2 29d. Date sign 5 + (104,05, Year) 29c. License number 29b. Signature and title MOD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 460 mo WIKEWS LOTHICAR gistrar's Signature State Registrar

			1 - For State of Maryland / Department of Head State of Maryland / Department of Head Certificate of of Hea		l Hygiene		6220
	Physici /Medio	al	1. Decedent's Name (First, Middle, Last)  Jeanne Faisant Gay  As Society Name (If not institution arise street and number)	05	5 10	2005 1	3. Time of Death  0:35 PM M
	Funeral	er	1 M 2 K F Months Days	Lle If Under 24 Hrs. 8. Date Hours Min. (Mo.	e of Birth	Country	ce (State or Foreign y)
	Director works	or	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location		11/1929	Mary 100	land  Inside City Limits  1 □ Yes 2 \ □ No
	ath with the A 23a or 28a-1 ust be notifi	Funeral Director	MD Baltimore Kingsville  10e. Street and Number 10f. Zip Code  11902 Cedar Lane 21087			izen of What Country	
900	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Itam 27 is marked othar than "natural; or itams 23a or 28a-f show other traumatic evant, the Medical Exstrict must be rediffed at	by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	anic Origin? (Specify Yes Mexican, Puerto Rican, e Specify:	es or No- etc.)	14. Race - Americar Black, White, etc Specify: Whit	c.
Maryland 21215-0036	filed within 72 h Hygiene. other then "netu ent, ire Medica	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  12  16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired)  Homemaker	on ing most of working		ind of Business/Indu	stry
aryland	2 should be file and Mental Hy is marked oth sumatic evant	To Be (	17. Father's Name (First, Middle, Last)	8. Mother's Name (First, Kathryn Sie	egert	,	Code)
	m O		George G. Gay (husband)  20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from State  1 1902 Cedar La  20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Lo	ocation - City or Town	
Baltimore,	permit. Page Department i Important: If eny injury or			<sup>of Facility</sup> E. F. r Road — Ki	Lassahn ngsvill	Funeral 1	Home, P.A.
	Pnysician /Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, s shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):		0	Ir	Approximate Interval Between Donset and Death
8760, 4	icate be executed physician and sthe burial-transit	icai Examiner					
.O. Box 6	that the death certifica ed by the attending ph detached for use as th	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □			23d. Date of delivery Month Da	ay Year
ords, P.	requires een sign rould be	by	Part it. Other significant continuous contributing to death but not resulting in the underlying cause given i	in Part I. 23e		se contribute to the	cause of death?
Vital Records,	The taw ate has b page 2 sl	e Completed			a. Was an autopsy performed? Yes 2 No	prior to comp death?	y findings available pletion of cause of
Division of Vi	Attanding Phys r death. actor: After this by the funeral di	Certification; To B	examiner?  1   Yes 2   No	4 Nursing Home 5 det 28d. Des	Residence e	d Number or Rural F	Route Number,
Õ	a Hospital or 124 hours afte e Funaral Dira letely filled in t	edicai Cer		date and place, and due	to the cause(s)	and manner as state	ed. ne cause(s)
)	To that within 2. To the I complet	Me	29b. Signature and title of certifier  29c. License nu  3 4 5	5390	mou	e signed (Month, Da	05
	10	to.	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  M70 MIN (M.D.) G02 Sowth Alwood R  31. Date filed (Month, Day, Year)  32 Registrar's Signature	oad # 200	, Bel +	fir, MD	21014
i	Sta Registr		MAY 1 3 2005  Registrar's Signature  MAY 1 3 2005				

			For Amend It	State of M ems 23d,25,27	laryland / Dep ,28a-f per	artment of	Health and i	Mental Hyg Ihb	giene leg. No.200	5 16221
	Physici		1. Decedent's Name (First, Mir Robert Loui	s Gilland, Sr				2. Date of Dea Month	th Day Ye	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institu	tion, give street and number	)	4b. City, Town	, or Location of Death		4c. County of D	V 1 V
	Exami	•	Union Memor	rial Hospital		Balti	more		n/a	
r	Funeral		5. Social Security Number	6. Sex 7. A	ge (In yrs. last birthday		ar If Under 24 Hrs.	8. Date of Birth (Month, Day	( Year) 9.	Birthplace (State or Foreign Country)
l.	Director		216-28-5804	1 M 2 □ F	73 Yrs.			Dec. 3	0 1931 <i>N</i>	!D
	and w		Usual Residence of Decedent 10a. State 10b. Cou		10c. City, Town or L	ocation				10d. Inside City Limits
	r 28a-f show	ţ	MD Ba	Itimore	Timoniu	m				1 ☐ Yes 2 ☐ No
	288	Director	10e. Street and Number		Timorna	10f. Zip Code	•		l 0g. Citizen of What	Country?
	death with the ms 23a or 28a r.must be noti	al D	405 Plumbrio	dge Ct. #403		210	093		П	SA
		Funeral	11. Marital Status	12. Was Deceden Armed Forces	t Ever in U.S. 13.		f Hispanic Origin? (Suban, Mexican, Puert	pecify Yes or No- o Rican, etc.)		American Indian, Vhite, etc.
36	₫ ō ₫	by Fu	1 Never Married 2 N	Married 1 ☐ Yes 2 ☐ If Yes, Give	Kyo	1□Yes 2€ N			Specify:	white
5-0036			3 Widowed 4 Divord	dent's Education		edent's Usual Occ	cupation		16b. Kind of Busine	
5	in 72 in 72	Completed	(Specify only hig	hest grade completed)	(Giv	e kind of work dor DO NOT use reti	ne durina most of wor	king	POD. KING OF BUSINE	issindustry
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	be filed within 72 hatal Hygiene. Id other than "netu	a)	17. Father's Name (First, Midd			Orricy	18. Mother's Nan	ne (First, Middle,	Maiden Sumame)	
<u> a</u>	uld bu Menta Irked Irked	To B	Louis A. Gil	lland			Hilda	Ulrich		
Maryland	s 1 and 2 should be I Health and Mental Item 27 le marked o other treumetic ev		19a. Informant's Name/Relation				et and Number or Ru			
	± 2		Sophia Gilla	nd/wife	405	Plumbrio	dge Ct. #		onium, M	D 21093
Baltimore,	m O		20a. Method of Disposition 1	on 3 Removal from State	20b. Place of Disp cemetery, cre			Date / 05	20c. Location - City	
ij	pernit. Page Department of Importent: If any njury or once		'4 □Donation 5 □ Other					odox Ch	Cem. Pa	rkville, MD
Bal	permit. Page Dependent Importent: if any injury or once		21. Signature of Fune at Six			2. Name and Add _emmon		ome of I	Dulaney V	/alley, Inc. 21093
100			Michael J.  23a. Part1. Enter the disease	or complications that cause	ed the death. Do not en	ter the mode of d	ndonia Rd.	Timon	ium, MD	21093 Approximate
	*		shock, or heart failure. I Immediate Cause (Final	ist only one cause on each	line.		h		,	Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)		SPIRATORY s a consequence of):	FAI	LURE			-6 HOCES
1	Examiner				STRICTIVE	LU	NG Dis	EASE		Turch
P.		ner	Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	U.	s a consequence of):					
	xecuted and I-transi	Examiner	Cause (Disease or injury that initiated events	o. LA		RITONE	ALA	SCITE	SI	2 weeks
0,	ate be executed nysician and he burial-transit		resulting in death) Last		s a consequence of):			1		
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9	death certificate e attending phys id for use as the	Physician/Med	IF FEMALE:	23c. If yes, outcom				/ //	OVED BY MEDICAL ED	AMINER
Box	eath atten for u	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth	2 Fetal death 3	□Ectopic pregnar □ Other (specify)	ncy GE	RTIFICATION APPR	Month	Day Year
P.O.	res that the designed by the a	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown						
	s that ned b e deta	y P	Part II. Othar significant cond	ditions contributing to death	but not resulting in the	underlying cause	given in Part I.	3e. Did to	bacco use contribut	e to the cause of death?
rds	w requires that the bean signed by the should be detached	ed b	COPD -	ROSEPSIS	- CORON	VARY AG	RPERY DIVE	SSE 10Y	es 2□No 3□	Probably 4 Unknown
000	> 0 %	Completed by	G-0UT .	RENAL IN	SURRICIENS	· -		24a. Was a	in 24b. Were	autopsy findings available to completion of cause of
Ä	9 4 9	mo;	DIARETE	s malinto	Status I	ost lef re	t leg	, perfor	med? death	1?
ita	ysiclen: Th is certificate director, pag	Be	25. Was case referred to med examiner?		FIACLU	LE		th (Check only or		
) \( \)	Physiclen: this certific ral director,	2	1X Yes <del>3€ No</del>	Hospital: 10X Inpat		nt 3 DOA			ence 6 🗆 Other (S	(pecify)
n	ng fter ine	on:	27. Manner of Death  13Natural 5 □ Per	28a. Date of Injury		W	ork?		ow injury occurred struck by	vehicle
Sio	Attending r death. actor: After by the funer	icat	LAL FROM GOTT	uld not be			∐Yes 2XNo			
Division of Vital Records,	or A after Direction by	Certification:	4 Homicide dete	ermined 288. Place of in building, e	njury - At home, farm, s tc. <i>(Specify)</i> +	геет, тастогу, оптс	e	City or Town	n, State Timoni	Lum, MD Lum, MD nia Rds,
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	S S	29a. Certifier 15 Certif	fying Physician: To the bes	t of my knowledge, dea	th occurred at the	time, date and place	, and due to the c	ause(s) and manner	r as stated.
	n 24 h	edical	(Check only 2 ☐ Media one)	cal Examiner: On the basis and manners	of examination and/or i	nvestigation, in my	y opinion, death occu	rred at the time, d	ate and place, and	due to the cause(s)
	To the To the Comp	Me	29b. Signature and title of cert	tifier		29c. Lice	nse number	2	9d. Date signed (M	onth, Day, Year)
			1		MD	D:	41637		APRIL 1	8,2005
(1	0)		30. Name and address of pers	on who completed cause of			1			· · · · · · · · · · · · · · · · · · ·
4			SAUM 2	K12K		ron w	EMORIAC	+20th -	J. GADI.	
	Sta Registr		31. Date filed (Month, Day, Ye		trar's Signature					
	3-1	100	MAY 1 2 20	111) Filedon	A LEXINEL					

		•	State State Amend Items 23c, 6	of Maryland / De , 25, 27, 28a-f	epartment of Health and Centricate of Beath 12	Mental Hygie /05dhb	ene 005 16222
	Physicia /Medic		1. Decedent's Name (First, Middle, Last)	E GREET	2	2. Date of Death Month	Day Year 3. Time of Death 1.7 2005 1.35 P. M
	Examin	_	4a. Facility Name (If not institution, give street and	number) GENERAL	4b. City, Town, or Location of Deat	h	4c. County of Death  How Mr. 5
	Funeral Director		5. Social Security Number 6. Sex 1	7. Age (In yrs. last birthe	Months Days Hours Min		(ear) 9. Birthplace (State or Foreign Country) Md
	Maryland f show	tor	Usual Residence of Decedent  10a. State 10b. County  Md Baltimore	10c. City, Town O	or Location wings Mills		10d. Inside City Limits 1 ☐ Yes 2 🏋 No
	with the 3e or 28a-	Funeral Director	10e. Street and Number 4509 Wards Chapel Road	<u> </u>	10f. Zip Code 21117	10g	Citizen of What Country?
936	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "naturel", or Items 23e or 28a-f show any injury or other traumatic event, the Medical Examination and the notified at once.	by	1 Never Married 2 Married 1 Yes,	ecedent Ever in U.S. Forces? s 2V No Give A	13. Was Decedent of Hispanic Origin? (5 If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 ☐ Mo Specify:	Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify:White
Maryland 21215-0036	within 72 horelene. than "naturelle Westernerelle	Completed	15. Decedent's Education (Specify only highest grade complete Elementary/Secondary (0-12)  Colleg	(d)	ecedent's Usual Occupation Give kind of work done during most of wo ife. DO NOT use retired) tockroom manager	rkina	b. Kind of Business/Industry otor Freight Express
land 2	uld be filed Aental Hygi rked other tic event, I	To Be Co	17. Father's Name (First, Middle, Last) George W. Green		18. Mother's Na Rosa E.	me <i>(First, Middl</i> e, <i>M</i> a De11	iden Sumame)
	and 2 shousalth and No. 27 is mailer traumailer		19a. Informant's Name/Relationship (Type, Print) Mary E. Green (spouse)	450	Mailing Address (Street and Number or R 9 Wards ChapelRd. (	Owings Mil	1s, Md 21117
Baltimore,	Pages 1: ment of He ant: if iten ury or oth		20a. Method of Disposition 1	III) State	oisposition (Name of crematory or other place) hapel UMC Cem. 3-2	1-05 Ra	c. Location - City or Town, State
Balt	permit. Depart Import any inj		21. Signature of Funeral Service Licensee  Sough Sought Service  23a. Part 1. Enter the disease, or complications the		22. Name and Address of FacilityHa: P.O. Box 195 Sykes	sville, Md	21784
2,0928	/Medical be executed / hysician and buysician and physician and physicia	dical Examiner	shock, or heart failure. List only one cause of limmediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, flash, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	to (or as a consequence of)	LEWA DISEASE	<u> </u>	Interval Between Onset and Death  Onset and Death
.O. Box 68	death certifi e attending id for use as	Physician/Medi	in the past 12 months?	outcome of pregnancy e birth 2  Fetal death egnant at time of death iknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
s, D	sign d be	by	Part II. Other significant conditions contributing t				cco use contribute to the cause of death?  2 □ No 3 □ Probably 4 □ Ūnknown
of Vital Record	The law ate has b page 2 sl	Completed				24a. Was an autopsy performe 1 ☐ Yes 2	24b. Were autopsy findings available prior to completion of cause of death?  No 1 Yes 2 No
Vita	Physicien: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?  1 X Yes  2010  Hospitaf: 1	☑Inpatient 2☐ER/Outp	Othor	ath <i>(Check only one)</i> Home 5 ☐ Residence	ce 6 ☐Other (Specify)
Division of	ng Ifter	Certification; T	27. Manner of Death  Shetural   5   Pending   (/h	ate of Injury 28b. Tin	ne of 28c. Injury at work?  NOWN M 1 Yes 2 No	28d. Describe how Probab]	injury occurred  Le fall
Ö	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	ledical Certi	29a. Certifier  1 Certifying Physician: To	ospital the best of my knowledge,	death occurred at the time, date and plac or investigation, in my opinion, death occ	e, and due to the cau:	State Hospital Center  TRO:,Randallstown,MD  se(s) and manner as stated.  a and place, and due to the cause(s)
	To the H within 24 To the F complete	Medi	29b. Signature and title of certifier	TENDING	29c. License number		Date signed (Month, Day, Year)  MAR 17 2005
	6		30. Name and address of person who completed of TANS TANN NO A	ause of death (Item 23a) (T		BACTION	
	Sta Registr		31. Date filed (Month, Day, Year) MAR 2 2 2005	2. Registrar's Signature	well .		

		1	For State Registrar	State of Ma	ryland /		rtment of H tificate of I		nd Mer		jiene eg. No.	05	16223
			Decedent's Name (First, Middle, Last)							Date of Dea	th		3. Time of Death
	Physicia		Judith D. Gubito	nsi						Month Lay 11	Day 2005	Year	1350 M
	/Medic Examin		4a. Facility Name (If not institution, give s				4b. City, Town, or	Location of			<del>-</del>	inty of Death	
	LXamiii		Suburban Hospital				Bethes	da			Mor	ntgome	ry
	Funeral		5. Social Security Number 6. Sex	7. Age	(In yrs. last b	irthday)	If Under 1 Year Months Days	If Under 2	4 Hrs. 8.	Date of Birth	Year)	9. Birth	place (State or Foreign intry)
	Director		092-03-8701	]M 2X F	88	Yrs.	Wionins Days	1.00.0	De	(Month, Day ec. 22	, 1916		Hampshire
	D > 100		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	wn or l o	cation						10d. Inside City Limits
	sho	5											1√T¥Yes 2 □ No
	the N	ect	Maryland Montgome  10e. Street and Number	ery	Kens	ingt	10f. Zip Code				l0g. Citizen	of What Cou	untry?
	with	ā					20895				United		
	eath	era	3620 Littledale Ro	12. Was Decedent E	ver in U.S.	13. V	Vas Decedent of H Yes, specify Cuba	ispanic Origi	in? (Specify			Race - Amer	ican Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: if Item 27 is marked other then "natural", or Items 23a or 28e-f show my injury or other treumatic event, Ite Madical Examiner must be notified at ance.	by Funeral Director	1 □ Never Married 2 □ Married 3 🏿 Widowed 4 □ Divorced	Armed Forces?  1 ☐ Yes 2 X No If Yes, Give Year or Dates:	0		Yes, specify Cuba □ Yes 2 🔀 No	n, Mexican, Specify:	Puerto Rica	an, etc.)		Black, White ec <i>ify:</i> עול	o, etc. ite .
21215-0036	2 hou	ted	15. Decedent's Edu	cation	16	a. Deced	lent's Usual Occup	ation	of working		16b. Kind o	f Business/l	
215	hin 7	Completed	(Specify only highest grad	College (1-4or 5+	-)	life. I	kind of work done of NOT use retired	duning most d)	or working				
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<u>ya</u>	ould Men Merke Marke	၉	Joseph Usko							Ltovic		- 61-1- 7	7- O-1-1
Maryland	and rising remains		19a. Informant's Name/Relationship (Ty				g Address (Street Bellevue						20814
	1 and Healt em 2 ther		Dennis McGuire/Son 20a. Method of Disposition	11	20h Place	of Dispo	sition (Name of					on - City or	
Baltimore,	ages int of t; if it		1 Burial 2 Cremation 3 F  4 Donation 5 Other (Specify)		Montg	one i	natory or other place		4ay <sup>Date</sup> 2005		Rathe	ada M	[aryland
를	artme orten injuri		21. Signature of Euneral Service bicens		Crema	22	. Name and Addre	ss of Facility	Rober	- t A .	Pumphi	rev Fu	neral Home/
Ba	Depar Impor any ir		1 NeidEle		00803	Be Be	ethesda-C ethesda,	hevy ( <u>Maryl</u> a	inase, and 2	. Inc. 20814-	7557 3501	Wisco	onsin Avenue
			23a. Part1. Enter the disease, or compleshock, or heart failure. List only of	lications that caused t ne cause on each line	the death. De	o not ent	er the mode of dyin	ig, such as c	ardiac or re	spiratory ari	est,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Pneumo									
г	Examiner			Due to (or as a Sepsis		e of):							
		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a		e of):					· · · · · · · · · · · · · · · · · · ·	-	
1/	uted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	Cardia	c Arre	est							
v Cî	execting and and rial-tra	Еха	resulting in death) Last	Due to (or as a	consequenc	e of):							
68760,	icate be executed physician and s the burial-transit	dical	(	d. Athero	sclero	tic	Heart Di	sease					
		0	IF FEMALE:	23c. If yes, outcome of	of pregnancy						224	Date of deli	von.
). Box	s death certific he attending p ed for use as	Physician/M	in the past 12 months?	1 Live birth 2 4 Pregnant at t	2 Fetal dea		Ectopic pregnancy Other (specify)	/			230.	Month	Day Year
P.O.	that the de ed by the a detached	Phy	9 ☐ Unknown  Part II. Other significant conditions co	entabuting to death bu	t not resulting	in the u	nderlying cause giv	en in Part I		23e. Did to	bacco use o	contribute to	the cause of death?
js,	es be	by	Chronic Obstruct				ndony ang oddae giv				es 2 N		obably 4 Unknown
Ö	w requires been sign should be	etec								24a. Was	an 2	th Were au	topsy findings available
Records,	has has	Completed	Atrial Fibrillat	1011						autop perfor	med?	prior to death?	completion of cause of
a	lan: The l rtilicate ha stor, page	e Co	Hypertension 25. Was case referred to medical					OF Place	of Dooth (C	1 Yes		1 ∐ Yes	2□ No
Vital	Physician: this certific ral director,	o Be	examiner?	Hospital: 1 X Inpatier	nt 2 🗆 ER/0	Outnatier	nt 3 DOA Oth	ar.		5 ☐ Resid		Other (Spec	cify)
of		-	27. Manner of Death	28a. Date of Injur	y 28t	. Time o				l. Describe h			
ion	Attending in death.	atio	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	( ear)	Injury		Yes 2 1	10				
Division	el or Attendi s after death. el Director: A ed in by the fu	iffic	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju		farm, sti	eet, factory, office		28f.	Location (S City or Tox	Street and Ni m, State)	umber or Ru	ral Route Number,
	tel or s afte el Dir ed in	Certification:											
	To the Hospitel of within 24 hours at To the Funerel D completely filled in	Medical	29a. Certifier (Check only one) Certifying Phy 2 Medical Exam	vsician: To the best of iner: On the basis of and manner state	examination.	lge, deat and/or in	n occurred at the til vestigation, in my o	me, date and opinion, deat	d place, and h occurred :	due to the dat the time, d	cause(s) and date and pla	d manner as ce, and due	stated. to the cause(s)
	To the To the Comp	Ž	29b. Signature and title of certifier	1,000			29c. Licens	e number			29d. Date si	gned (Monti	n, Day, Year)
			Mag	Vaca	2		D536	91			May 1	2, 200	)5
	À		30. Name and address of person who c					1	1- 34	1	J 00	017	
	9		Ajay Reddy, M.D.  31. Date filed (Month, Pay, Year)	6320 Demo	ocracy r's Signature	Bou	revard, b	setnes	da, Ma	ary⊥ar	ia 20	817	
	Sta Regist		MAY 1 3	2005			berti						
			- 0 .	A. L. Marie	in f		1042						

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05 00-07	
James F.	

	03239 es F. H	acl	map, 1- Stata Amend Item	State of Ma 1 per me G8	aryland 343 5	d / Der -13-0	artmen Stiliest	t of H e of L	ealth a	and M		gieņe Reg. No.	05	162	24
			1. Decedent's Name (First, Middle,	Last)						Ĭ	2. Date of De Month		Vees	3. Time of	Death
	Physicia /Medic		James Frederic	k Hackman,	Jr.						May 09	200	5 Year	2:15	РМ
	Examin		4a. Fecility Name (If not institution,	give street and number)			4b. City,	Town, or	Location of	f Death		4c. Co	ounty of Death	1	
	£ .		Laurel Regional	Hospital				Laur	el			Pri	ince Ge	orge's	
	Funeral Director		216-62-3830	5. Sex 7. Ag 1 ★ M 2 ☐ F	e (In yrs. I 49	ast birthda Yrs.	Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bird (Month, Da Dec • 8	th y, Year) 1955	9. Birth Cou 5 Mar	place (State o intry) yland	r Foreign
	pu 🛊 🙄		Usual Residence of Decedent  10a. State 10b. County		10c City	, Town or	ocation						T	10d. Inside Ci	ity I imits
	sho	7	MD Howard	l		ridge								1 ☐ Yes	·
	8a-f	ecto						0.4.				10- 02:	n of What Cou		
	vith t	Funeral Director	10e. Street and Number				10f. Zip							mury :	
	s 23	ra	6400 Sedgwick S		Constantin	D 45		.075		===2 (C==	-it. Vac as No		USA . Race - Amer	ican Indian	
	er de Item	nu	11. Marital Status	12. Was Decedent Armed Forces?		5.	If Yes, spe	cify Cuba	n, Mexicar	gin? (Spe i, Puerto	ecify Yes or No Rican, etc.)	-	Black, White		
36	s aft	by F	1 ☐ Never Married 2 🔀 Marrie 3 ☐ Widowed 4 ☐ Divorced	d 1 XYes 2 ☐ 1 If Yes, Give Year or Dates:]			1 🗌 Yes	2 No	Specify:			S	pecify: w	hite	
8	within 72 hours after death with the Maryland ene. Than "naturel", or Items 23e or 28e-f show he Medical Evanimer must be notified at	De L	15. Decedent's		L9/3-		edent's Usu	al Occup	ation			16h Kind	of Business/I	ndustry	
<u>.</u>	n 72 "na edic	Completed	(Specify only highest	grade completed)		(Giv	e kind of wo	rk done d	during mos	of worki	ing	TOD. Raing	0, 2001103011	ioustry	
12	withi ene.	m	Elementary/Secondary (0-12)	College (1-4or 5	5+)		nager		,			Fune	ral Ser	vice	
2	filed Hygie other	ŏ	17. Father's Name (First, Middle, L	ast)					18. Mothe	r's Name	(First, Middle,				
aŭ	ould be i Mental arked o atic eve	) Be	James Frederic	. Hackman, S	Sr.				Evely	m My	rtle S	euss			
2	hould d Me mark matic	ဥ	19a. Informant's Name/Relationsh			19b Ma	iling Address	(Street	and Numbe	or Or Bura	il Route Numb	ar City or 7	Town State Zi	in Code)	
Maryland 21215-0036	d 2 s th an 17 is treu	3	Mary K. Hackman				-				Elkridge				
	1 an Heal em 2 ther		20a. Method of Disposition		20b. P	ace of Dis	position (Na	ne of			ate	20c. Loca	ition - City or T	own, State	
و	Pages nent of t ent: If its ury or o	- 1	1 Burial 2 Cremation			-	iematory`or o Lle Ve			5/1	3/2005	Crow	mesri 11	a MD	
Baltimore,	it. P.		' 4 □ Donation 5 □ Other (Sp 21. Signature of the of Service I		CLOV										
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturely, or Items 23e or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at once.		21. Signature de l'iner de l'iner	) /	1012	20 G	ary L	Kau	ifman	Fune	eral Ho	me@Me	eadowri	.dge MP,	Inc.
			23a. Part1. Enter the disease, or o shock, or leart failure. List of	omplications that caused			250 Wa	shir	igton g such as	Blvc	I., Elk	ridge.	, MD 2	21075 Approximate	0
	Physician /Medical Examiner	ner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions if any, leading to immediate cause. Enter Undertying	a. Due to (or as	a consequ	ence of):	ii (	eno	liova	SCU	lar I	Desi	all	Interval Bett Onset and I	Death
68760,	death certificate be executed e attending physician and nd for use as the burial-transit	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	a consequ	uence of):									
.O. Box	the death certify the attending	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal	death 3	B⊟Ectopic p i □ Other (sp					236	d. Date of deliv Month	-	Year
rds, P	w requires that the debeen signed by the a should be detached f	by	Part II. Other significant condition	s contributing to death b	ut not resi	alting in the	underlying o	ause giv	en in Part I		23e. Did t		contribute to No 3 ☐ Pro	the cause of d bably 4 □L	
Records,	Physicion: The law requires that the this certificate has been signed by the tall director, page 2 should be delached.	Completed									24a. Was auto perfo		24b. Were aut prior to co death?	opsy findings a completion of ca	available ause of
ta	ien: rtifice stor, p	Bec	25. Was case referred to medical						26. Place	of Death	(Check only o				
>	ysic is ce direc	ToE	examiner? 1 XYes 2 No	Hospital:	ent 2 💢	ER/Outpat	ient 3 DC	Oth	er: 4□Nu	rsing Ho	me 5 🗆 Resi	dence 6 [	Other (Speci	ify)	
Division of Vital	ling After fune		27. Manner of Death Natural 5 Pending investig		ry Year)	28b. Time Injury	of A	28c. Injun Worl	yat k? Yes 2 □		28d. Describe	how injury o	occurred		
Divis	or At ifter c Sirec in by	Certification;	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	28e. Place of Inj building, et	ury - At ho c. (Specify	me, farm,	street, factor	y, office			28f. Location ( City or To		Number or Rui	al Route Num	ber,
	To the Hospitel or At within 24 hours after d To the Funerel Direct completely filled in by	Medical		Physicien: To the best xeminer: On the basis o and manner st	f examina										i)
	To ti To ti comp	X	29b. Signature and title of certifier	1Am/	N	1	29	c. Licens OCM	e number E				signed (Month		
11	714		30. Name and address of person v	no completed cause of c	death (Item	23a) (Typ	e, Print)	Der	CL		Do1+4-		10 2005		1
10	Sta	ato.	31. Date filed (Month, Day, Year).	OWAN 32. Registr	ar's Signa	ture A	TTT	renn	Stre	et	Baltimo	ore, N	arylan	d 2120	Τ
	Regist		31. Date filed (Month, Day, Year)	UUD THE STATE		Contract of the second									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician Nelson /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner HARFORK enter 9. Birthplace (State or Foreign Country) MARYLAND If Under 1 Year If Under 24 Hrs. 6. Sex 1 M 2 ☐ F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Min. 214-12 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Items 23a or 28a-f show any injury or other traumatte avant. In Medical Examinations or other traumatte avant. In Medical Examinations or other traumatte avant. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 No Be Completed by Funeral Director 10g. Citizen of What Country? 10e. Street and Number Ove 12. Was Decedent Ever in U.S. Armed Forces? 1 ØYes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 KNo Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) thoara 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) alter 1/1/0 ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Re ationship (Type, Print 20b. Place of Disposition (Name of 20c. Location - City or Town, State lorenco 20a. Method of Disposition
1 □ Burial 2 CCremation 3 □ Removal from State
1 □ Donation 5 □ Other (Specify) cemetery, crematery or other place -10-05 FOREST EVANS FUNERALCHAPEL+ 21. Signatus of Funeral Service Licensee 22. Name and Address of Facility FORESTHILL, MO 21050 EVANS FUNERAL CHAPEL-BELAIR 3 NEW PORT BE 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Findisease or condition resulting in death) Pnysician 4 days o or es a con /(€IAI /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Be Completed by Physician/Medical attending p 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.0. detached 9 Unknown 9 🗌 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions Vital Records, 1 Yes 2 10 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed 1 ☐ Yes 2 210 Physician: 25. Was case examiner? 26. Place of Death (Check only one) Hospital: Other: Inpatient 4 Nursing Home P 1 Yes 2 NO 2 EP/Outpatient 3 DOA 5 Residence 6 ☐Other (Specify) of 27. Man of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Medical Certification: 28c. Injury at Work? To the Hospital or Attending Division 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier within 24 ho To the Funs completely f 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cau of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

32. Registrar's Signature

			1- For State of Maryland / Dep. State of Maryland / Dep. Ce	artment of Health and M		211115 16226
	*		Registrar  1. Decedent's Name (First, Middle, Last)	lincate of Death	2. Date of Death	3. Time of Death
Г	Physici		Juanita M. Hungerford		Month	Day Year 8:13 A M
	/Medic Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	124 31	4c. County of Death
			3810 Contees Wharf Ln.	Edgewater		Anne Arundel
	. Funeral	Г	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, )	9. Birthplace (State or Foreign Country)
	Director		219–12–4471 1 M 2 F 81 Yrs.		10-27-19	Washington, DC
	land		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Lo	ocation		10d. Inside City Limits
	Mary -fah	to	Maryland Anne Arundel Edge	ewater		1 □ Yes 2 <b>□X</b> No
	n the	rec	10e. Street and Number	10f. Zip Code	100	g. Citizen of What Country?
	th wit	Funeral Director	3810 Contees Wharf Ln.	21037		USA
	r dea	Iner	11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces?	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto F	city Yes or No-	14. Race - American Indian, Black, White, etc.
36	s afte , or it	by Fu	1 ☐ Never Married 2 【X Married 1 ☐ Yes 2 【XNo	1 ☐ Yes 2 ☑ No Specify:		Specify: White
Ö	hour turai	ed b		dent's Usual Occupation		
15	n "na	Completed	(Specify only highest grade completed) (Give	kind of work done during most of workir DO NOT use retired)	ng le	6b. Kind of Business/Industry
212	d with giene Hr tha	mo	Elementary/Secondary (0-12) College (1-4or 5+)  12th	Homemaker		Home
2	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "natural", or items 23s or 28s-f ahow aumatic evant, the Madical Examiner must be mailined at	BeC	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Ma	
<u>a</u>	should b ind Menti a markad umatic e	To	Thomas E. Miller	Henr:	ietta Mar	rtin
Maryland 21215-0036				ng Address (Street and Number or Rura		
	1 and Health am 27 thar tr	3		Contees Wharf Ln.		
altimore,	Pages 1 nent of H int; If ita iry or ot		i de pousi 2 de cremation 3 de movai from State	matory or other place)		c. Location - City or Town, State
≣	it. Pag rtment rtant; i njury o			ans Cemetery 5-9-0		rownsville, MD
Ba	permit. Pages Department of Important; if i any injury or once.		1111-17/11/2			Kalas Funeral Home
			23a. Part1. Enter the disease, or complications that caused the death. Do not ent	2973 Solomons Islar	nd Rd. Ec	dgewater, MD 21037
	Physician		Immediate Cause (Final		,	Interval Between Onset and Death
	/Medical		disease or condition resulting in death)  Due to (or as a consequence of):	carer		
	Examiner					
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
	ecuter ind trans	Examiner	that initiated events C.			
60,	be exician sourial	Ē	Due to (or as a consequence of):			
98760	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dlcal	d			
×	eath certific attending p I for use as I	Physician/Me	IF FEMALE: 23c. If yes, outcome of pregnancy	,		2010111
Box	eath atter	clar	in the past 12 months?	Ectopic pregnancy Other (specify)		23d. Date of delivery  Month Day Year
Ö	at the de by the a	nysl	1 Yes 2 No 4 Pregnant at time of death 5 5			
ري ح	res that igned to be det	by P	Part II. Other significant conditions contributing to death but not resulting in the un	iderlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death?
ğ	w require been sig should b		galter Mellitus		1 ☐ Yes	2 No 3 Probably 4 Unknown
ecords,	aw re	ompleted	Khumatold Arthur		24a. Was an	24b. Were autopsy findings available
I	The lay ate has page 2	Com			autopsy performed	prior to completion of cause of death?  No 1 Yes 2 No
Vital	sician: The certificate irector, pag	Bec	25. Was case referred to medical examiner?	26. Place of Death		12.103
010	ys Si	2	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien	t 3 DOA Other: 4 Nursing Hom	e 5 Residenc	e 6 Other (Specify)
	ding Ph h. After th funeral	on:	27. Manner of Ceath 28a. Date of Injury 28b. Time of Injury (Month, Day Year) 28b. Time of Injury	Work?	8d. Pescribe how	injury occurred
200	ttand death tor: / the f	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 300 Bloom of letters At home formula.	M 1 ☐ Yes 2 ☐ No		
UIVISION	spital or Attanours after deat ours after deat sarai Director; filled in by the	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm, street building, etc. (Specify)	et, factory, office	City or Town, S	et and Number or Rural Route Number, State)
	spital ours narai filled		29a. Certifier  Chock only  Ch	occurred at the time, date and place, as	ad due to the ease	0(a) and
	To the Hospital or Attanding F within 24 hours after death. To the Funaral Director: After completely filled in by the funer.	edical	(Check only one) 6 Medicel Exeminer: On the basis of examination and/or invone)	estigation, in my opinion, death occurred	d at the time, date	and place, and due to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)
	1		taul me motion mil	1 00894		15/05
	15		30. Name and address of person who completed cause of death (Item 23a) (Type,		· · · · · ·	1-1-
	\			ly Ave., Annapolis,	MD 2140	
	Sta Registra	_	MAY 1 3 2005  31. Date filed (Month, Day, Year)  MAY 1 3 2005	and I		
100	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		THE THE POOL OF THE PARTY SA. TO.			

			1- For State of Ma	•	artment of Healt		eg. No. 005	16227
	Physici /Medic		1. Decedent's Name (First, Middle, Last)  MARY E • HAYMAKER			2. Date of Dea Month MAY 05,	Day Year	3. Time of Death 4:55 a <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, give street and number)  WILSON HEALTH CARE CENTER  5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday)	4b. City, Town, or Locat GAITHERSBU If Under 1 Year   If Un	RG	4c. County of Dea	RY
	Funeral Director		226-98-9022 1 M 2XX 93 Usual Residence of Decedent	Yrs.	Months Days Hou		Year) Co 1912 V	thplace (State or Foreign buntry) IRGINIA
	the Marylar 28a-f show	ector	MD MONTGOMERY	GAITHERS	BURG			10d. Inside City Limits 1 □ ¥es 2 □ No
	23a or 2 ust be n	Dir	301 RUSSELL AVENUE		10f. Zip Code 20877		10g. Citizen of What Co USA	ountry?
920	after dea or items	l by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 XWidowed 4 Divorced  12. Was Decedent Examed Forces?  1 Yes 2 2 No. 1 Yes 2 Year or Dates:	) I	Was Decedent of Hispanic If Yes, specify Cuban, Mex 1 ☐ Yes 2 ☐ No Spe		14. Race - Ame Black, Whit Specify: WI	
21215-0036	na Fina	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+	(Give	dent's Usual Occupation kind of work done during a DO NOT use retired) DMEMAKER	most of working	16b. Kind of Business.	·
Maryland 2	s 1 and 2 should be filed withir f Health and Mental Hygiene. item 27 ia marked other than other traumatic event, It a M	To Be C	17. Father's Name (First, Middle, Last)  ROY C. CROWDER			other's Name (First, Middle,	Maiden Sumame)	
Mar	d 2 sho th and 7 is m traum		19a. Informant's Name/Relationship (Type, Print)  L. ROBERT HAYMAKER		ng Address (Street and Nu RCHARD ROAD	umber or Rural Route Numbe EGG HARBOR T		
Baltimore,	Pages 1 and Pent of Health of: If item 27 ry or other tr		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  4 Qonation 5 Other (Specify)	20b. Place of Dispo	osition (Name of matory or other place)	Date 05-09-05	20c. Location - City or	Town, State
Balti	permit. Pages 1 Depirtment of H Important: if ita any injury or otl		21. Signature of Euneral Service Licensee	22	2. Name and Address of F		UNERAL HOMI	
3760,	Physician and /Medical Examiner phe prival-Itansit	licai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	consequence of		l infanci Lineari		Approximate Interval Between Onset and Death
.O. Box 68	that the death certifics ed by the attending pt detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome o 1 □ Live birth 2 4 □ Pregnant at ti	Fetal death 3	□Ectopic pregnancy □ Other (specify)		23d. Date of del Month	livery Day Year
Records, P	The law requires ate has been signi page 2 should be	Completed by Ph	Part II Other significant conditions contributing to death but as chemical canditions  Lindafacency and materials and alleling	repopeta Les Che Ofter as	brie gaste.	1 Y	an 24b. Were at	robably 4 Unknown utopsy findings available completion of cause of
ion of Vital	Attending Phyaician: Th r death. actor: After this certificate by the funeral director, pag	ation: To Be	27. Manner of Death 1 Matural 5 Pending 2 Accident 28a. Date of Injury (Month, Day)	t 2 ER/Outpatier 2 28b. Time of 1 Injury	nt 3 DOA Other: 4			icity)
Division	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injurbulding, etc.	ry - At home, farm, str (Specify)	reet, factory, office	28f. Location (S City or Tow	treet and Number or Re n, State)	ural Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Dirac completely filled in by	edicai	29a. Certifier (Check only one)  1 Certifying Physician: To the best of and manner state	examination and/or in	h occurred at the time, dat vestigation, in my opinion,	e and place, and due to the c death occurred at the time, c	ause(s) and manner as ate and place, and due	s stated. a to the cause(s)
	To th withir To th	Σ	29b. Signature and title of certifier	- an	29c. License numb	ber 2	29d. Date signed (Mont	h, Day, Year)
	le		NAME and address of person who completed cause of de LACOBERT BIRSCHIBALL	ath (Item 3a) (Type,	Print PIRUS	RSBURG,	148 200	77
	Sta Registi	ite ar	31. Date filed (Month, Day, Year)  WAY 1 3 2005	s Signature	ade			

		1 - For State Of Registrar			artment of F tificate of			Reg. No.	2005	1622
Physici /Medi		Decedent's Name (First, Middle, Last)     BARBARA A. HANKS					2. Date of De Month MAY	Day	Year <b>700</b> 5	3. Time of Death 0659 A
Examir		4a. Fecility Name (If not institution, give street and number 51 MAI HOSPITHE OF	Δ.	Thure	1. 1	Location of Death	city	4c.	County of Death	
Funeral Director		5. Social Security Number 216-54-0634 6. Sex 1 M 2 F 7. /	Age ( <i>In yr</i> s. 64	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi	1940	9. Birthp	place (State or Forei LAND
land ow		Usuel Residence of Decedent  10a. State 10b. County	10c. Cit	ty, Town or Lo	cation				1	Od. Inside City Limit
a-fsh	ctor	MARYT AND NA	P	BALTIMORE	2					1 ☐ Yes 2 ☐ N
n with the	ai Dire	10e. Street and Number 740 POPLAR GROVE ST. APT. 4J			10f. Zip Code 21216			10g. Citiz	zen of What Cour	ntry?
gos 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mantal Hygiene. If flem 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event. Its Madical Exam	by Funeral Director	11. Marital Status  1	s? No	] ]	Vas Decedent of H I Yes, specify Cuba □ Yes 2√2 No	ispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)		14. Race - Americ Black, White, Specify: AFRIC	etc. CAN
72 hou natura		15. Decedent's Education (Specify only highest grade completed)		16a. Deced	lent's Usual Occup	ation during most of wor	kina	16b. Kir	AMERI and of Business/In-	
within ene. than *	Completed	Elementary/Secondary (0-12) College (1-40 NA	r 5+)	life. L	OO NOT use retired KEEPER	1)		AT ON	CE CLEANIN	G SERVICE
uld be filed Mental Hygi arked other itic event.	To Be Co	17. Father's Name (First, Middle, Last) NAPOLEAN HANKS		1		18. Mother's Nan JO HORTON	ne (First, Middle	, Maiden	Sumame)	
2 should and Missing		19a. Informant's Name/Relationship (Type, Print)			g Address (Street				Town, State, Zip	Code)
os 1 and 2 of Health item 27 other tra		NATHANTEL RUSSELL SON  20a. Method of Disposition		Place of Dispo	27th STRE sition (Name of		ORE, MARY		21211 cation - City or To	own. State
Z 2 2 2		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State  4 ☐ Donation 5 ☐ Other (Specify)			atory or other place PARK CEME		4, 2005		US, MARYL	
permit. Page Department o Important: If any injury or		21. Signature of Funeral Service Licensee	_		Name and Addre					,
rnysician /Medical Examiner		23a. Part1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each Immediate Cause (Final disease or condition resulting in death)  a	sis							Onset and Death
e executed ian and urial-transit	dicai Examiner	Sequentially list conditions.	as a conseq	nce of):	J					2 wak
e executed an and urial-transit	1 1	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9  Unknown	as a consequence of pregna 2 ☐ Feta at time of d	uence of):  ancy I death 3 leath 5 leath	Ectopic pregnancy Other (specify)					Day Year
e executed an and urial-transit	by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	as a consequence of pregna 2 ☐ Feta at time of d	uence of):  ancy I death 3 leath 5 leath	Other (specify)			obacco us	Month	Day Year
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The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant conditions contributing to death  HIV ADS; MAS 4  25. Was case referred to medical examiner?	as a consequence of pregna 2 Feta at time of design but not reserved.	ancy a death 3 Leath 5	Other (specify)	en in Part I.  26. Place of Dea	24a. Was autor performed to Yes	obacco us Yes 2  an psy primed? 2 No	Month se contribute to th No 3 Prob 24b. Were auto prior to cor death? 1 Yes	Day Year  ne cause of death? ably 4 Unknow  psy findings availab  mpletion of cause of
Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rall director, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No   Yes	as a consequence of pregna 2 Feta at time of definition of definition of definition of the constant of the con	ancy al death 5 Coulting in the ur	Other (specify)	26. Place of Dea	24a. Was autor performed to Yes	obacco us Yes 2 an an psy primed? 2 No	Month se contribute to th No 3 Prob 24b. Were auto prior to cor death? 1 Yes	Day Year  ne cause of death? ably 4 Unknow  psy findings availab  mpletion of cause of
iling Physician: The law requires that the death certificate be executed to the continuous security and the continuous security security.	To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No   23c. If yes, outcom 1   Live birth 4   Pregnant 9   Unknown  Part II. Other significant conditions contributing to death HIV AT DS; MAS 4  25. Was case referred to medical examiner? 1   Yes 2   No   Hospital: 1   Impart of It   25. Was case referred to medical examiner? 1   Yes 2   No   Hospital: 1   Impart of It   26. Pending investigation 3   Suicide 6   Could not be determined   26. Place of It   Could not be determined   26. Place of It   See Place of It   26. Place of It   Month, It   26. Place of It   26.	as a consequence of pregna 2 Feta at time of definition of definition of definition of the constant of the con	uence of):  uence of):  uence of):  uence of):  uence of):  uence of):  uuence of):  uuence of):  uuence of):  uuence of):  uence of):  ue	Other (specify)	26. Place of Dea	24a. Was autoj perfici 1 Yes th (Check only come 5 Residue) 28d. Describe in	obacco us Yes 2 an psy psy primed? 2 No pne) dence 6 how injury	Month se contribute to th No 3 Prob 24b. Were auto prior to cor death? 1 Yes	Day Year  ne cause of death? ably 4 Unknow  psy findings availab  mpletion of cause of
fing Physician: The law requires that the death certificate be executed n. After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit	Certification: To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No   23c. If yes, outcom 1   Live birth 4   Pregnant 9   Unknown  Part II. Other significant conditions contributing to death HIV AT DS; MAS 4  25. Was case referred to medical examiner? 1   Yes 2   No   Hospital: 1   Impart of It   25. Was case referred to medical examiner? 1   Yes 2   No   Hospital: 1   Impart of It   26. Pending investigation 3   Suicide 6   Could not be determined   26. Place of It   Could not be determined   26. Place of It   See Place of It   26. Place of It   Month, It   26. Place of It   26.	as a consequence of pregna 2 Feta at time of definition of definition of definition of the definition of examina at the definition of examination at the definitio	ancy al death 3 death 5 death 6 death	Other (specify)  Inderlying cause give  Local Control  28c. Injun Word  M 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	26. Place of Dea Br: 4 \sum Nursing H / at // at // at // ac	24a. Was autoperforment of the Check only only only only only only only only	obacco us Yes 2 an ppsy rrmed? 2 No one) dence 6 how injury	Month  se contribute to the No 3 Prob  24b. Were autorous for to cordeath? 1 Yes  Other (Specify occurred	Day Year  ne cause of death? ably 4 Unknow  psy findings availab  mpletion of cause of 2 No  //
Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1	as a consequence of pregna 2 Feta at time of definition of definition of definition of the definition of examina at the definition of examination at the definitio	ancy al death 3 death 5 death 6 death	Other (specify)  Identying cause give  Local Section of the sectio	26. Place of Dea  26. Place of Dea  ar: 4 \( \) Nursing Ho  y at  k?  Yes 2 \( \) No	24a. Was autop performence of the Check only only only only only only only only	obacco us  Yes 2  an psy prmed? 2 No pne)  dence 6 how injury  Street and wm, State)  cause(s) a date and	Month  se contribute to the contribute to the contri	Day Year  ne cause of death? ably 4 Unknow  psy findings availab  mpletion of cause of  2 No  //  //  // Route Number,  ated. the cause(s)

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

O.b		<ol> <li>Decedent's Nam</li> </ol>	ie (First, Middle, Las	t)				2. Date of I			3. Time of Death
Physic /Med		Lyman Hop	pkins					May 6	, 2005	Year	1025 A-M
Exami			If not institution, give		)		or Location of Dea	th	4c. Cou	unty of Death	
			pkins Hos			Baltimo				NA	
Funeral Director		5. Social Security N 220–90–3836	5 11	7. A	ge (In yrs. last birti	hday) If Under 1 Year Months Days		(Month, L	Birth Day, Year) <del>.936</del> <b>196</b> 9	9. Birthi Coul Mary	place (State or Foreigr ntry) Land
<b>≱</b> _		Usual Residence o	10b. County		10c. City, Town	or Location					10d. Inside City Limits
ma 23a or 28a-f show	ō	MD	, ,								1 X Yes 2 No
28a-	ect	10e. Street and Nu	NA mber			Baltimore	<u> </u>		10g Citizon	of What Cou	
Sa or						Toil Zip Code	21202		Tog. Onizen	Of What Cour	nuy:
78 Z	Funeral Director	11. Marital Status	orth Avenue	12. Was Decedent	t Ever in U.S.	13. Was Decedent of h		Specify Yes or N	USA 14. I	Race - Americ	can Indian
Department of Health and Mental Hyglene.  Inportant: If itam 27 Is marked other than "natural", or itama 23a or 28a-1 shoy inportant: If itam 27 Is marked other than "natural", or itama 23a or 28a-1 shoy injury or other traumatic event. The Medical Examinar must be notified at once.	þ		ried 2 Married 4 Divorced	Armed Forces 1 ∐Yes 2 XX II Yes, Give Year or Dates:	? No	13. Was Decedent of It Yes, specify Cub		to Rican, etc.)		Black, White, ac <i>ify:</i> Blac	etc.
natural', or ita ilcal Examine	ted	(600)	15. Decedent's Ed	ucation	16a.	Decedent's Usual Occup	pation		16b. Kind o	of Business/In	
E S	Completed	Elementary/Seco	cify only highest grad ondary (0-12)	College (1-4or		(Give kind of work done life. DO NOT use retire	d) auring most of wo	rking			
= =	00	9				Handy M	an		Home	e Improv	rement
doth	Be	17. Father's Name	(First, Middle, Last)				18. Mother's Na	me (First, Midd	le, Maiden Sun	name)	
arka atic	2	Steve C	ook	****			Carl	en Hopki	ns		
and Is m		19a. Informant's N	ame/Relationship (7	ype, Print)	19b.	Mailing Address (Street	and Number or R	ural Route Num	ber, City or To	wn, State, Zip	Code)
ealth n 27 er tr		Delores You				308 Homewood A	venue Balt:	imore, MD	21202		
of Hi if itar		20a. Method of Dis	position Cremation 3 [	Removal from State		Disposition (Name of crematory or other pla	сө)	Date	20c. Location	on - City or To	own, State
ant: I			5 Other (Specify		Trinity	Cemetery	05-1	13-05	Baltimo	ore, MD	
Departi Import any inj once.		21. Signature of Fu	uneral Service Licens	800		22. Name and Addre	ss of Facility				
ă			The	~		Wylie Funera	1 Home 638	N. Gilmon	r St. Bal	to. MD	21217
		23a. Part1. Enter t	the disease, or comp	dications that cause	d the death. Do no	ot enter the mode of dyi	ng, such as cardia	c or respiratory	arrest,		Approximate Interval Between
kaminer					S a consequence o	Cardiovascu	ılar Dise	ease			
	I Examiner	Sequentially list co if any, leading to in cause. Enter Unite Cause (Disease or that initiated events resulting in death)	onditions, nmediate any G any G any G any G any G	Due to (or as		f): f):	ılar Dise	ease			
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this certificate has been signed by the attending physicien and ral director, page 2 should be detached for use as the burial-transit	Certification: To Be Completed by Physician/Medical	25. Was case referexaminer?  27. Wanner of Deat  27. Wanner of Deat  28. Was case referexaminer?  29. Wanner of Deat  Natural  2   Accident  3   Suicide  4   Homicide  29a. Certifier (Check only one)  29b. Signature and	anditions, mediate shall be considered to medical standards. In the pregnant standards and the medical shall be considered to medical shall be considered t	Due to (or as b. Due to (or as c. Due to (or as d. Due to	s a consequence of pregnancy 2 Fetal death at time of death of time of death of the consequence of examination and a consequence of examination an	f):  3	yen in Part I.  26. Place of De. ier: 4□ Nursing H y at k? Yes 2□No  me, date and place pinion, death occuse number	23e. Did  1 24a. Wa autoper 1 1 24 24 25 26 26 26 26 26 26 26 26 26 26 26 26 26	tobacco use colored tobacc	Month ontribute to the allowing autoprior to cordeath? 1 New Yes Other (Specify curred) manner as stee, and due to the autoprior to cordeath? 2005	Day Year  The cause of death?
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year 1018 AM Flore ones 200. /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner of Baltimore
If Under 1 Year If Under 24 Hrs. university Morry/and Medical Center 5. Social Security Number 6/Sex Age (In yrs. last birthday) 8. Date of Birth (Month, Day) 9. Birthplace (State or Foreign **Funeral** Days 1 M 2 F Hours 070.60.5044 Yrs. **Director** NEW Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.

Is marked other than "natural", or Itams 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic avant, the Medical Examiner must be notified at 1 Yes 2 No Completed by Funeral Director MD SERMAN TOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 19108 Vas Decedent Ey Armed Forces? ☐ Yes 2 1 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Coban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 2 M No Yes, Give ear or Dates: BLACK Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) MANAGER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be PARBARA MHCHEU MOUKE 2 permit. Pages 1 and 2 shc.
Department of Health and M.
Important: If itam 27 is meany Injury or other. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 121 4 Date MOTHER 20a. Method of Disposition
1 Burial 2 Cremation 20b. Place of Disposition (Name of cemetery, crematory or other place) 3 Removal from State \* 4 □ Donation 5 □ Other (Specify) BREENMOUN 21. Signature of Funeral Service Licensee Name and Address of Facility ROAD w 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Necro /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760. the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Day Year 4 Pregnant at time of death 5 Dther (specify) Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 No 3 Probably 4 Unknown Be Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ Yes 2 ☐ No 24a. Was an autopsy performed? certificate has Yes 2 🗆 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: Certification: To 2 No Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation after death 2 Accident 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral D 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the 29a, Certifier Medical Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the

Registrar DHMH 17 Rev 1/200

State

0

29b. Signature and title of certifier

30. Name and address of person who

31. Date filed (Month, Day, Year) MAY 1 3

GREENE

S.

completed cause of death (Item 23a) (Type, Print)

32. Registrar Signature

HUCK

10417985

BALTO, MO

29d. Date signed (Month, Day, Year)

Christopher Lee Johnston Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 05-03162 State of Maryland / Department of Health and Mental Hygiene RPD 1 - State Registrar Certificate of Death Rea. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 6, ohnston **Physician** 2005 onek 2027 P /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner North Arundel Hospital Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Month, Day Way 31, 5. Social Şecurity Number 7. Age (In yrs last birthday) 9. Birthplace (State or Foreign **Funeral** 12 M 2□ F dd 187-62-8433 Director ennsylvania Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County itam 27 is marked other than "natural", or items 23e or 28e-f show other treumatic evant, the Madical Examinar must be matified at Odenton 1 ☐ Yes 2 ☐ No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 509 Kealm death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. nent of Health and Mental Hygiene. ant: if itam 27 is marked other than "natural", or Itel 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NQT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sandwich ath 18 Mother's Name (Firşt, Middle, Maiden Sumame) Rather's Name (First, Middle, Last) Be ashington Dandera W Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Ryral Route Number, City or Town, State, Zip Code) 5/0 ord ham Father 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State ö permit. Page Department of Importent: If any injury or once. Crematory 5 Other (Specify) 4 Donation Funeral Se lice Lix nsee 22 Name and Address of Facility define disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Hang /Medical Due to (or a a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed attending physician end for use as the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐ Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Vinknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 27es 2 □ No 24a. Was an certificate has page 2 autopsy performed 2 No 1 Yes To the Hospitei or Attending Physician: filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: <u>L</u> 1X Yes 2 No 1 Inpatient 2 ER/Outpatient 3 □ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of Injury /Month, Day 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending invostigation 4(830 HRS 515/05 1 Yes 2 Accident 28f. Location (Street and Number or Rural Floute Number, City or Town State) 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office determined building, etc. ity or Town, State) within 24 hours a To the Funerel I 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical

State

Registrar

THEUDORE 31. Date filed (Month, Day, Year)

29b. Signature and title of certified

MAY 1 3 2005

32. Registrar's Signature

29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Prill Penn Street Baltimore, Maryland 21201

OCME

29d. Date signed (Month, Day, Year)

May 7, 2005

			State of Maryland / De 1- State Amend Items 23C, 25, 27, 28a-f per	partment of Health and N r MF G843 05/12/05 erificate of Death	lental Hyg dhb	iene) 0 0 5	6232	
	Physicia	an	Decedent's Name (First, Middle, Last)     Evelyn R. Jones		2. Date of Deat Month April	Day Year	Time of Death	
L	/Medic Examin	al	4a. Facility Name (If not institution, give street and number) Bon Secour Hospital	4b. City, Town, or Location of Death Baltimore	Aprii	4c. County of Death		
	Funeral Director		5. Social Security Number  212 28 4866  6. Sex 1 □ M 2 図 F 74  7. Age (In yrs. last birthda Yrs. 1 → 1 → 1 → 1 → 1 → 1 → 1 → 1 → 1 → 1	y) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Jan. 19	9 Birthplace	(State or Foreign	
	and w		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or	Location		10d. in	nside City Limits	
	a-f sho	ctor	Maryland N/A Baltin	nore		1	XYes 2 No	
:	a or 28	Directo	10e. Street and Number 2019 Wilhelm Street	10f. Zip Code 21223	1	0g. Citizen of What Country?		
(0	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. and Mental Hygiene. Its marked other than "natural", or Items 23s or 28s-f show aumatic event, the Medical Examinat must be notified at	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 \( \text{Never Married} \) 2 \( \text{Married} \) Married  1 \( \text{Yes} \) 2 \( \text{\text{M}} \) No	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American In- Black, White, etc.	dian,	
00	ural', o	d by	3 Widowed 4 X Divorced Fixer or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify: White  16b. Kind of Business/Industry	,	
Maryland 21215-0036	hin 72 i	Completed	(Specify only highest grade completed) (G	cedent's Usual Occupation ive kind of work done during most of work b. DO NOT use retired)	ing	Tob. Kind of Business/Industry	i	
7	filed wit Hygiene ther the		11th Was	18. Mother's Nam		Restaurant		
lanc	uld be f dental } rked of tic eval	To Be	Albert Vogel		yn Koch	,		
Mary	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marke any injury or other traumatic once.			ailing Address (Street and Number or Rui Wilhelm Street		; City or Town, State, Zip Code e, Maryland 21		
	es 1 and 3 of Health fitem 27 r other tr		20a. Method of Disposition 20b. Place of Disposition	222		20c. Location - City or Town, S		
	Pages tment of I tant: If its jury or o		1  Burial 2	ill Cemetery 4/20	the state of the s	Baltimore, Mar		
Ball	permit. Departr Imports any inj		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Go 4001 Ritchie Highwa				
	nysician		23a. Part 1. Enter the disease, a symplications that caused the death. Do not shock, or heart failure. List only one cause on sch line.  Immediate Cause (Final disease or condition	enter the mode of dying, such as cardiac	or respiratory arm	est, Applinter	roximate rval Between et and Death	
760, <	ate be executed which in the burial-transit	Ilcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):   Dislodged PEG Tul	1	DEY MEDICAL EXAMINE	hous		
.O. Box 68	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med		3 Ectopic pregnancy 5 Other (specify)		23d. Date of delivery Month Day	Year	
rds, P.	quires that in signed build be deta	by	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Party.	23e. Did tol	bacco use contribute to the causes 2 \(\sigma\) No 3 \(\sigma\) Probably		
		Completed	Coronary Artory Dio	ease /	24a. Was a autops perform 1 Yes	y prior to complete	ion of cause of	
Vita	Physician: The this certificate ral director, pag	o Be	25. Was case referred to medical examiner?  1 X Yes 2 Hospital: 1 Department 2 ER/Outpa	Othor	th (Check only on	ence 6 (Other (Specify)		
lon of	nding Phys th. r: After this e funeral di	1	27. Manner of Death 1 CARTOTAL 5 Pending (Month, Day Year) 2 Accident 28a. Date of Injury (Month, Day Year) 2 Accident April 2005	e of 28c. Injury at	28d. Describe ho	ow injury occurred ed PEG tube		
Divis	al or Atta s after des il Directo ed in by th	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, building, etc. (Specify)  Hospital	street, factory, office	28f. Location (Si City or Town Bon Seco	treet and Number of Rural Roy n, State) Baltimore ours Hospital	te Munber.	
	To the Hospital or Attanding Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical (	29a. Certifier (Check only one)  1		red at the time, d	ate and place, and due to the		
}	To t com	M	29b. Signature and title of certifier Romalo 6	29c. License number	3	9d. Date signed ( <i>Month, Day,</i>		
	6		30 Name and address of person who completed cause of death (Item 23a) (Ty	pe, Print) Homen Jal	7000	118 Raftimas	2005	
	Sta Registi		31. Date filed (Month, Day, Year)  32. Registrar's Signature  MAY 1 2. 2005	or Partitly		CAT THINK		

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2005 **Physician** May 11, 11:48AM Vincent Lawrence Johnson /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Chevy Chase Montgomery Manor Care-Chevy Chase If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthdey) 8. Date of Birth (Month, Day, Year) 6. Sex Birthplace (State or Foreign Country) **Funeral** Hours Days Months 1⊠M 2□ F Yrs. 86 Director 471-09-9878 Oct. 26, 1918 Minnesota Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours efter death with the Meryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumetic event, the Medical Exercities. 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Funeral Directo Bethesda Maryland| Montgomery 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 10241 Farnham Drive 20814 United States 12. Was Decedent Ever in U,S. Amped Forces? 1 ∰ Yes 2 □ No World If Yes, Give Year or Dates: War II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 🕅 No Specify: Specify: Completed by 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Deputy Associate Administrator for Space Science NASA 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Jennie Davidson Philip E. Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 20814 Shirley H. Johnson/Wife 10241 Farnham Drive, Bethesda, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cometery, crematory or other place)
Montgomery May 12 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State riúm, Inc. | 2005 | Bethesda, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue 4 ☐ Donation 5 ☐ Other (Specify) Crematorium, Inc. 21. Signature of uneral Service Liceusee M00803 20814-3501 Bethesda, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final diseese or condition resulting in death) /Medical Advanced A Glie were Examiner Due to (or as a consequence of) Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of) end Division of Vital Records, P.O. Box 68760; physician Due to for as a consequence off 23b. Did tobecco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I 3 Probably 4 Onknown 1 ☐ Yes 2 ☐ No Completed by 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 1 Tyes 2 No Be 25. Was case referred to medical examiner? 26. Plece of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No this 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 1-Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No s efter death.

i Director: Al death. 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours e To the Funeral C completely filled McCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. edicai 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier DO054566

15+1 State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sunita Bhogavili, 1220 A Fait suppa Road Seet 230 Towson MD21286

31. Dete filed (Month, Day, Year)
MAY 1 3 2005

32. Degistrar's Signeture

			1 - State Registrar	ate of Maryland / De	partment of F ertificate of			giene Reg. No. 005	16234				
			1. Decedent's Name (First, Middle, Last)				2. Date of Dea	ath	3. Time of Death				
	Physici		Gregory Allen	Koehler			May 10	Day Year	11:58P M				
	/Medio Examir		4a. Facility Name (If not institution, give street	and number)	4b. City, Town, o	or Location of Death		4c. County of Death	<del></del>				
	ZX		Kline Hospice House		Mount	Airy		Frederic	:k				
	Funeral		Social Security Number     6. Sex.	7. Age (In yrs. last birthda	y) If Under 1 Year	If Under 24 Hrs.	8. Date of Birt (Month, Da)	h 9. Birth	nplace (State or Foreign untry)				
	Director		216-50-8807 1AM 2	□ F 56 Yrs.	Months Days	Hours Min.	January	25, 1949	lashington D				
	pr ,		Usual Residence of Decedent										
	aryta ehov	<u>_</u>	10a. State 10b. County	10c. City, Town or					10d. Inside City Limits				
	Be-f	cto	Maryland Frederick	Freder	ick				1 ☐ Yes 2 🔀 No				
	within 72 hours after death with the Maryland ene. than "natural" or Items 23a or 28e-f show he Medical Examinar must be notified at	Funeral Director	10e. Street and Number		10f. Zip Code			10g. Citizen of What Co	untry?				
	ath w	Ta .	6104 Pine Crest La		21701			U.S.A.					
	er de	une	Ar Ar	as Decedent Ever in U.S. 13 med Forces?	<ol> <li>Was Decedent of F If Yes, specify Cub</li> </ol>	Hispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White					
36	s afte	<u>&gt;</u>	If `	]Yes 2.21Mo ∕es, Give	1 ☐ Yes 2 🛣 No	Specify:		Specify:					
Ö	hour tural	Completed by	15. Decedent's Education	ar or Dates:	andant's House Occur	-ation		wnı					
<u> 7</u>	n 72 "na	lete	(Specify only highest grade com	oleted) (Gi	cedent's Usual Occup ve kind of work done DO NOT use retire	during most of worki d)	ng	16b. Kind of Business/I	ndustry				
2	with ene. than	Ĕ	Elementary/Secondary (0-12) Co	III (1-4015+)	o Body Me			Automotiv					
0	filed Hygi ther		17. Father's Name (First, Middle, Last)	110	o body me	18. Mother's Name	(First, Middle,						
an	d be ental	To Be	Francis Joseph Ke	oehler		Lucille	Mildr	ed Wood					
Maryland 21215-0036	Shoul nd M mari	F	19a. Informant's Name/Relationship (Type, Pr	int) 19b. Ma	iling Address (Street	and Number or Rura		r, City or Town, State, Z.	ip Code)				
<b>≥</b>	permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Department of Heelth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f ehow eny Injury or other traumatic event, the Medical Examinar must be natified at once.		Maureen T. Koehler										
ō,	Hee Hee tem othe		20a. Method of Disposition	20b. Place of Dis	position (Name of rematory or other pla	est Lane,	rreder ate	ick, Maryla 20c. Location - City or 1					
5	ages ent of it: If I		1 ☐ Burial 2 🕅 Cremation 3 ☐ Remove 4 ☐ Donation 5 ☐ Other (Specify)				5/12/05	Alexandri	a Virginia				
Baltimore,	artme ortan Injur		21. Signature of Funer I Service Licensee										
Ba	Depa Impo eny k		Hovert L.	alliano !	Olin L. Mo	lesworth	P.A., F	uneral Home					
			23a. Part1. Enter the disease, or complication	s that caused the death. Do not e	nter the mode of dyir	ge Koad, ng, such as cardiac o	Damascu or respiratory ari	s, Maryland	Approximate				
			shock, or heart failure. List only one cau	se on each line.		1	,		Interval Between Onset and Death				
	Physician /Medical		mmediate Cause (Final issesse or condition esulting in death)  a. adenocarcinoms of the esophagus 9/27/09  Due to (or as a consequence of):										
	Examiner				done so	CO. 25 -2 -	of the	cocc. a.dall	1/5/00				
212		er		Due to (or as a consequence of):	veria Cui	CINDAIL	prosid	Occipital	113109				
13	uted f	ᄪ	cause. Enter Underlying Cause (Disease or injury	A trophic 1	at eral	Sclar	0515		8/21/04				
2 .	sician and sician and burial-transit	Examiner	resulting in death) Last	Due to (or as a consequence of):		JC1~1			010101				
DEN ME 68760,	death certificate be executed e attending physician and of for use as the burial-transit	call		muscle spas	ms and	Pasiculat	7015		Soste <				
989	ificate g phy		u	J		7,0-101	10:13						
6 K Box	uires that the death certifica signed by the attending ph d be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 23c. If y	es, outcome of pregnancy				23d. Date of deliv	rery				
() m	death a atte	cla	in the past 12 months?	Pregnant at time of death	B □Ectopic pregnancy B □ Other (specify) _	у		Month	Day Year				
0	that the ed by the detacher	nys	9 Unknown 9E	Unknown									
(/) <b>&amp;</b>	s that ned b	by P	Part II. Other significant conditions contributi	ng to death but not resulting in the	underlying cause giv	ven in Part I.	23e. Did to	bacco use contribute to	the cause of death?				
5 E	quire; n sig		Malignont Hyp	ertension, T	OBACCO	abuse,	1 <b>X</b> Y	es 2□No 3□Pro	bably 4 Unknown				
اکر ecord	w requ	lete	Hypertensive st	roke 6/02			24a. Was a	an 24b. Were aut	opsv findings available				
2) ~	The law requires ate has been sign page 2 should be	Completed	17/200				autop: perfor	med? death?	ompletion of cause of				
Vital	iclan: Th certificate rector, pag	e C	25. Was case referred to medical			Of Blace of Death	1 Yes		<b>X</b> ∟No				
	Physiclan: r this certific ral director,	OB	examiner? 1 ☐ Yes 2 📉 No Hospita	l: 1 ☐ Inpatient 2 ☐ ER/Outpati	ont 30 DOA Oth	26. Place of Death			4.1 TT				
$\stackrel{\diamond}{\circ}$	ding Phys	$\vdash$		. Date of Injury 28b. Time	of 28c. Injur	ry at 2		ence 6X1Other (Speci ow injury occurred	Mospice				
O	ding th: : Afte	100	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) Injury		rk?  Yes 2∐No							
Division	Atter dea	ertification:	3 ☐ Suicide 6 ☐ Could not be 286	. Place of Injury - At home, farm,	street, factory, office	2		treet and Number or Rui	al Route Number,				
ο	afte Dire		4 Homicide	building, etc. (Specify)			City or Tow	n, State)					
	spite nours nera / fille	alC	29a. Certifier La Certifying Physician:	To the best of my knowledge, de	ath occurred at the tir	me, date and place, a	and due to the c	ause(s) and manner as	stated.				
	To the Hospitel or Attending Physician: The law requir within 24 hours after death.  To the Funeral Director: After this certificate has been si completely filled in by the funeral director, page 2 should	edical	Check only 2 Medical Examiner: O	n the basis of examination and/or and manner stated.	investigation, in my o	ppinion, death occurre	ed at the time, d	late and place, and due	to the cause(s)				
	To th Withir To th comp	Me	29b. Signature and title of certifier		29c. Licens	e number	2	9d. Date signed (Month,	Day, Year)				
	11		lana P	XI and in	DO	73468	2	May 12, 200	05				
1	5		30. Name and address of person who complete	ed cause of death (from 23a) (Typ		00/04							
1	<u></u>		Joanne L. Kinney,			reet, Dan	mascus,	Maryland :	20872				
	Sta		31. Date filed (Month, Day, Year)	32 Pontario Signaturo	-								
	Registr	ar	MAY 1 3 2005	Sugare A.	MARIE								

amend item#15, perfff, G843,5/13/05 TT

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician K: HRELL Month Year EdWARd 2005 11:45A M ma /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town or Location of Death 4c. County of Death Examiner A Medical BALtimoRe NIA BALLimoRe If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1[**X**M 2□ F Director 409-36-0971 1928 Arkansas Apr. Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic avant, the Madical Exerciper count be notified at Maryland N/ABaltimore ¹X Yes 2 □ No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ŏ 21216 2725 Walbrook Avenue Apt.211 USA items 23a Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married ŏ Maryland 21215-0036 1 ☐ Yes 3 ☐ No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced natural 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mentat Hygiene. int: If itam 27 Is marked othar than ' Elementar/Secondary (0-12) 12trh grade College (1-4or 5+) Maryland Drydock grade Pipe Fitter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Ernest Kittrell Estella Wilkins 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda G. Thomas/ Niece 602 Queensgate Rd Baltimore, Maryland 21229 othar Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 5/16%05 . Cem. 20c. Location - City or Town, State Garrison Forest Vet. t Burial 2 ☐ Cremation 3 ☐ Removal from State ŏ Owings Mills, Md permit. Page Department of Important: If any injury or once. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facil@hatman-Harris Funeral 21. Signature of Funeral Service Licersee 5240 Reisterstown Rd Baltimore, Md lerry Tyans 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death POXIA **Physician** disease or condition resulting in death) /Medical Examiner mothoRAX Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner RuftuRe or Attanding Physician: The law requires that the death certificate be executed burial-transit OBSTRUCTIVE PULMONARY DISEASE Box 68760. the t IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy į in the past 12 months?
1 Yes 2 No Month Day 4□Pregnant at time of death 5 Other (specify) P.O. detached þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown funeral director, page 2 should Be Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No FiBR: LLATION H+RiAL 2 No 1 Yes 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending Injury death. investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) To the 29b. Signature and title of confifier P18564 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GREENC BALTIMORE MACKENZie CARPENTER, My State Registrar

			For State Registrar	State of Maryland		rtment of H		Mental Hy	rgiene 0 0 E	16236
	Physici	an -	1. Decedent's Name (First, Middle, Last)	i) II .				2. Date of D	eath Day C	3. Time of Death
	/Medic	cal	MARIAN  4a. Eacility Name (If not institution, give s	Kelly		4b. City, Town, or	Location of Deat	May	4c. County of E	09 1,50 pm
	Examir	ner	Good Samari	tan Hospita	$\mathcal{D}$	Balt	More		AC. COUNTY OF	TA.
	Funeral		Social Security Number     6. Sex	M 20 F 7. Age (In yrs. las	**	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Bi	rth 9.	Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent	M 2017	Yrs.			7eb 2	20,1928	MD
	yland how		10a. State 10b. County	10c. City,	Town or Lo					10d. Inside City Limits
	8e-fa	ctor	MD NA			BALTIM	one			1  Yes 2 No
	with the or 2	Funeral Director	10e. Street and Number  5500 Knell	1:10		10f. Zip Code	206		10g. Citizen of Wha	
	ms 23	nera		2. Was Decedent Ever in U.S.	13. V	Vas Decedent of Hi Yes, specify Cubar		Specify Yes or N		American Indian,
98	or Ita	y Fui	1 Never Married Married	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give	-	Yes 2 No	Specify:	to Rican, etc.)	0 1/	Vhite, etc.
215-0036	filed within 72 hours after death with the Maryland Hyglene. ther then "natural", or Itams 23a or 28e-f ahow ther, the Medical Examinar must be notified at	Completed by	3 Widowed 4 Divorced	Year or Dates:		ent's Usual Occupa	ition		16b. Kind of Busin	white
215	thin 72 B. Ben "ne Medit	plet	(Specify only highest grade	completed)  College (1-4or 5+)	(Give life. L	kind of work done a OO NOT use retired,	uring most of wo	rking		ood maasky
2	filed with Hygiene ither the	Con	12th	MA		Teller	40.14-1-1-1	· · · · · · · · · · · · · · · · · · ·	BANK.	
Maryland	id be fi ental F ked ot c evar	To Be	17. Father's Name (First, Middle, Last)  Tames Kus				MAR 4	Bedne	, Maiden Sumame)	
ary	2 should be and Mental Is marked o	-	19a. Informant's Name/Relationship (Ty)	oe, Print)	19b. Mailin	g Address (Street a			er, City or Town, Sta	re, Zip Code)
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Menial Hygiene. Important: if item 27 is marked other then "natural", or Items 23a or 28e-f ahow apply injury or other traumatic event, the Medical Examiner must be notified at once.		EDWARD He			Knell A	Ve, BA	1to. Md		
Baltimore,	ages int of h		20a. Method of Disposition  ☐ Burial 2 ☐ Cremation 3 ☐ R	emoval from State	netery, cren	natory or other place	5/		BA 1 to	
altin	permit. Pag Department Important: I any injury conce.		* 4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service License		LAWN 22	. Name and Addres				
ä	Depar Impo any ir		faul yn. E	tella	75	RTIEY Mil	lek - 31	Bolto A	eral Home AD 21234	
			23a. Part 1. Enter the disease, or compli- shock, or heart failure. List only on	cations that caused the death.	Do not ente	er the mode of dying	g, such as cardia	c or respiratory a	urrest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequen	/ <u> </u>					
	Examiner		Sequentially list conditions		108 01).					
J	sit sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequer	nce of):					
V	be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a consequer	nce of):					
8760,	sate be ex hysician the buria									
ж 68	ertifica ling ph e as th	Med	IF FEMALE:							
Вох	eath certific attending p	Physician/Medical	in the past 12 months?	3c. If yes, outcome of pregnanc 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of deat	eath 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
P.O.	that the dead by the detached	hysi	1 ☐ Yes 2 M2No 9 ☐ Unknown	9□ Unknown						<u> </u>
ls, F	Se us	by	Part II. Other significant conditions con	tributing to death but not resulti	ng in the ur	iderlying cause give	n in Part I.			e to the cause of death?  Probably 4 Onknown
Records,	w requir been si should	Completed						24a. Was		autopsy findings available
Re	The lay	ошо						auto		to completion of cause of 1?
		BeC	25. Was case referred to medical examiner?					ath (Check only	one)	
of \	ya Si Si	၉	1 Yes 2 No		VOutpatien	3 DOA Othe	4 Nursing		dence 6 Other (5	Specify)
	ling After une	tlon	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	28c. Injury Work M 1 □ Y	at ? ′es 2 □ No	28d. Describe	now injury occurred	
Division	I or Attandii after death. Diractor: A I in by the fu	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, stre	eet, factory, office			Street and Number o. wn, State)	Rural Route Number,
Q	pital o		On Continue of Figure 1							
	To the Hospital or within 24 hours afte To the Funeral Direction completely filled in h	edicai	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of my knowle ler: On the basis of examination and manner stated.	and/or inv	estigation, in my op	e, date and place iinion, death occi	e, and due to the urred at the time,	date and place, and	r as stated. due to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. License			29d. Date signed (M	onth, Day, Year)
			> The	-R.		1	0018	730	May 4	2005
	01		30. Name and address of person who co	SHA SHID	3a) (Type, I	AN 510	01 Lou	230 Rave	n Blvd.	pattimore md 71729
	Sta	201	31. Date filed (Month, Day, Year)	32. Sigistrar's Signatur	8	· · · · ·	9, -99	,	1- 101	I I'V LILD
	Registr	ar	MHI T 2 50	US Blicer B	1	ed				

amend item 2a, parts, CA3, 120/05 Hindelible Ink. Ensure All Copies Are Legible.

		For State Registraramend i	tem #8 per f	Maryland / Dep	artment of H <i>rtificate of L</i>	ealth a Death		Reg. No."	005	16237
Physici	an	1. Decedent's Name (First, Mic	Idle, Last)				2. Date of D Month May 5,	2005	Year	3. Time of Death
/Medic		ROBERT 4a. Facility Name (If not institut	BRAN		KRAUS 4b. City, Town, or				County of Death	4:28 P M
Examin	ier	9244 Countess		,	Pikesvill		INGS MILLS		ltimore	
Funeral		5. Social Security Number	6. Sex 7.	Age (In yrs. last birthday)	If Under 1 Year	If Under 2			-1981 Birth	place (State or Foreign
Director		219-02-8023	1√M 2□F	23 Yrs.	Months Days	Hours	Min. (Month, D	981	Cou	place (State or Foreign ntry) MD
pue *		Usual Residence of Decedent 10a. State 10b. Cour	ıtv	10c. City, Town or L	ncation					10d. Inside City Limits
daryie f sho	ъ	MD BALTI	•	OWINGS MI						1 ☐ Yes 2√ No
death with the Marylen ms 23s or 28s-f show	Director	10e. Street and Number	HOKL	OWINGS MI	10f. Zip Code	<u> </u>		10g Citiz	en of What Cou	
3a or	<u> </u>	9244 COUNTES	S DRIVE		21117			_	U.S.A.	, .
72 hours after death with the Maryland 72 hours after death with the Maryland inatural; or Items 23a or 28a-f show sical Executor rust be notified at	Funeral	11. Marital Status	12. Was Decede	nt Ever in U.S. 13.		spanic Origi	n? (Specify Yes or N Puerto Rican, etc.)		4. Race - Ameri	
after or Ite		1 Never Married 2 M	Armed Force arried 1 ☐ Yes 2 If Yes, Give	No No	1 ☐ Yes 2 ☐ No	n, mexican, Specify:	Puerto Rican, etc.)		Black, White	
"natural, or Item	d by	3 Widowed 4 Divorc	ed Year or Date					`	Specify: WH	ITE
d within 72 ho	Completed		ent's Education hest grade completed)	(Give	dent's Usual Occupa kind of work done of DO NOT use retired.	lurina most a	of working	16b. Kin	d of Business/Ir	ndustry
within ene. then "	duc	Elementary/Secondary (0-12	College (1-40	or 5+)	O SALESMA			D	ETAIL	
be filed htal Hygie od other svent, I	Be C	17. Father's Name (First, Midd	e, Last)	VIDE	O STILLSTIT		s Name (First, Middle			
	To B	GEORGE	WILLIAM	KRAUS	E	ADRIE	ENNE		KL	EGER
d 2 should th and Mer ty is marke traumatic		19a. Informant's Name/Relation	nship (Type, Print)	19b. Maili	ng Address (Street a	nd Number	or Rural Route Numb	er, City or	Town, State, Zij	Code)
		GEORGE WILLIA	M KRAUSE/FAT		COUNTESS	DRIVE			•	
360		20a. Method of Disposition  1 Disposition  2 Crematio	n 3 □Removal from Sta	10	matory or other place		Date		ation - City or T	
Pages tment of I tent: if it		' 4 □ Donation 5 □ Other	(Specify)	SHAAREI T	FILOH CON		5/08/2005		LAWN, M	
permit. Pages 1 ar Department of Hea Importent: if item any injury or othe		23a. Part1. Enter the disease, shock, or heart failure. Limmediate Cause (Final disease or condition resulting in death)	Drug	8	900 REIST	ERSTOV	SOL LEVIN NN ROAD -	PIKES	VILLE.	INC. MD 21208
cate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	as a consequence of): as a consequence of):						
the death certific y the attending p iched for use as	hysician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal death 3 tat time of death 5	□Ectopic pregnancy □ Other (specify)			23	3d. Date of deliv Month	ery Day Year
sa us e	by P	Part II. Other significant cond	itions contributing to death	n but not resulting in the u	nderlying cause give	n in Part I.	23e. Did 1 🗆		2	he cause of death?
e law has b	Completed						24a. Was		24b. Were auto prior to co death?	psy findings available mpletion of cause of
_ w o	e Co	25. Was case referred to medi	nal				1 Tes	2 No	1 ☐ Yes	2□ No
	0 B	examiner?  1 X Yes 2 No	Hospital:	ationt 2 PEP/Outnotion	Othe		of Death (Check only		Floring (County	
ing Phy After this	H .	27. Manner of Death 1 Natural 5 Pen	28a. Date of Indiana	niury 29h Time o	f 28c. Injury Work	at	0 - 1	how injury	occurred	^
2 4 4 5 E	Certification;	3X Suicide 6 □ Cou	d not be 28e. Place of	Injury - At home, farm, streetc. (Specify)			28f. Location	wn State	Number or Rura	al Route Number,
To the Hospitel within 24 hours e To the Funeral C completely filled		(Check only 212) Medic	ring Physician: To the be al Examiner: On the basis	st of my knowledge, deat of examination and/or in	h occurred at the tim vestigation, in my on	e, date and inion, death	place, and due to the	cause(s) a	nd manner as s	tated. the cause(s)
thin 2 the mplet	Medical	one) 29b. Signature and title of certi	and manner	stated.	29c. License					
7 × 00	-	- 1. A L A	2 Meo l	~ 115	OCN				signed (Month,	uay, rear)
1.	-	20 Name and address of	D up a paralata i	(double of the				May 6	, 2005	
Ψ			reen berg p	1.0	111 Per	n Str	eet Balti	more,	, Maryla	and 21201
Sta Registr		31. Date filed (Month, Day, Yea MAY 1 3	2005 A Regi	strar's Signature	E)					

Physi					00,	05713/0 tificate o	Deal			Reg. No.	L U U	10/
	ician	1. Decedent's Name (First, Middle Patricia Ann							2. Date of De Month April		Year	3. Time of Death
/Med	dical					45 Cit Tour		/ D+h			2005 County of Death	1:47 AM
Exam	niner	4a. Fecility Name (If not institution, 3607 Coolidge	e Avenue	Der)		4b. City, Town Balt:	imore	n or Death		40. (	county or Death	1
Funera			6. Sex 7 1 ☐ M 2 ☒ F	Age (In yrs. lass		If Under 1 Yes		er 24 Hrs. Min.	8. Date of Bi (Month, D.	rth sy, Year)	9. Birth	nplace (State or Forei
Directo	or	213-38-8823 Usual Residence of Decedent	- A	63	Yrs.				May 14	<b>,</b> 194	1 Wes	st Virgini
ahow ahow		10a. State 10b. County		10c. City, T	Town or Lo	cation						10d. Inside City Limi
8a-f	cto	MD		Ва	altimo				,			1√7Yes 2□N
a or 2	Dire	10e. Street and Number	A			10f. Zip Code		0		10g. Citiz	en of What Col	untry?
me 23	era	3607 Coolidge	12. Was Deced	lent Ever in U.S.	13. V	Was Decedent of	2122 Hispanic	Origin? (Sp	ecify Yes or No	o- 1	USA 4. Race - Amer	rican Indian,
is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 le marked other than "natural", or Iteme 23a or 28a-f show other treumatic avent, the Modical Examiner must be notified at	by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 🏋 Widowed 4 ☐ Divorced	ed 1 Tes 2 If Yes, Give Year or Date	. No	i	fYes, specify Ci 1□Yes 2∏ N			Rican, etc.)		Black, White Specify: whi	
72 ho	Completed	15. Decedent (Specify only highes		1	(Give	ient's Usual Doo kind of work dor	ne durina m	ost of work	ing	16b. Kin	d of Business/I	ndustry
within ane then	mp	Elementary/Secondary (0-12)	College (1-4	4or 5+)	life. E	DO NOT use reti	ired)				<i>5</i> 1	~
Hygir Hygir other	60	17. Father's Name (First, Middle, L			erec	tronics		ther's Name	e (First, Middle		of de: Gumame)	tense
nould be fited within a Mental Hygiene. narked other than natic avent, the M	To B	Harold Dale Me	tz				V	elma .	Alice P	hilli	ps	
alth and Men 27 to marke r treumatic		19a. Informant's Name/Relationsh Douglas Leathe				g Address <i>(Str</i> e ohnny L					Town, State, Zi 21666	ip Code)
permit. Pages 1 and 2 Department of Health a Important: If item 27 Is Iny injury or other tre		20a. Method of Disposition  1 Burial 2 Cremation  4 XDonation 5 Other (Sp		com		sition (Name of natory or other p	niace)	ľ	Date	20c. Loc	ation - City or 1	Town, State
- E E E	once.	21. Signature of Euneral Service L Ronald S	1////	1000 X	Ва	Name and Add ate Ana ltimore	, MD	2120	1		imore	Street
Physiciai /Medica	_	23a. Part1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	only one cause on eac	ch line.	. (	er the mode of d	,	1 -	or respiratory a	rrest,		Approximate Interval Between Onset and Death
Examine	12			r as a consequen	nce of):	PART 1.10.	20000		7	7		1 desir
Ite be executed lysician and ne burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or Injury that initiated events resulting in death) Last	b. Lung Due to (or	metasta rasa consequen	nce of):					000	rey	1 year
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		1 - For State Registrar	State of Maryland /	Depa		lealth and M	lental Hygie	•	5   1623
Physici /Medic Examir	cal	Decedent's Name (First, Middle, Last)  Les  4a. Facility Name (If not institution, give	ie G. Ludlum		4b. City, Town, o	r Location of Death	2. Date of Death Month May	Day Yea 11 2005 4c. County of De	6:00 A <sup>M</sup>
Funeral Director		145 40 6203	7. Age (In yrs. last)	birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day, Y NOV 17,	Howar 1941 I	rd irthplace (State or Foreign County) reland
be filed within 72 hours after death with the Maryland hat Hygjene. Ad other than 'nature'; or items 23a or 28a-f show event, the Medical Example must be motified at	Director	Usual Residence of Decedent  10a. State 10b. County  MD Howard  10e. Street and Number	10c. City, To					0.00	10d. Inside City Limits 1 ☐ Yes 2 🐼 No
death with ns 23s or	Funeral Dir	8630 Tower Drive	12. Was Decedent Ever in U.S.	13.	10f. Zip Code 20723 Was Decedent of H	ispanic Origin? (Spe		United S	-
72 hours after of naturel; or Item	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1  ☐ Yes 2		If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	ispanic Origin? (Spe in, Mexican, Puerto Specify:	Rican, etc.)	Black, Wh	
I within 72 h iene. r than "natu	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	dent's Usual Occup kind of work done of DO NOT use retired	durina most of worki	ng 16	b. Kind of Busines  None	s/Industry
	To Be C	17. Father's Name (First, Middle, Last) Wilton Flynn				Carmela	4	iden Sumame)	
permit. Peges 1 and 2 should Department of Health and Mer Important: if Item 27 ie marks eny Injury or other traumatic once.		19a. Informant's Name/Relationship (Ty, Kenneth E. Ludlum/ 20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License	Husband 8 emoval from State 20b. Place cemei	630 of Dispo tery, cren O Cr	Tower Dr. sition (Name of natory or other place cematory	5-14- ss of Facility Ham	1 MD 207 20 -2005 C TY H. Wit	723 c. Location - City of catonsvil zke's Fa	or Town, State
Cate be executed /Medical Examiner burial-transit sthe burial-transit	dical Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence Du	e of):	er the mode of dyin	g, such as cardiac o	r respiratory arrest		Approximate Interval Between Onset and Death 5 Min UT
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signed be de	by	Part II. Other significant conditions con	tributing to death but not resulting	in the ur	nderlying cause give	on in Part I.		co use contribute to	to the cause of death?
The law ate has b page 2 sh	Completed						24a. Was an autopsy performed 1 Yes 2X	prior to death?	utopsy findings available completion of cause of s 2 🛣 No
To the Hospitel or Attending Physicien: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	Certification; To Be	25. Was case referred to medical examiner? 1   Yes   2X No	28a. Date of Injury (Month, Day Year)  28b. Care Place of Injury - At home, building, etc. (Specify)	Time of Injury	28c. Injury Work M 1 🗆 Y	at 2 No	ne 5 XResidence 8d. Describe how	njury occurred t and Number or R	ecify) iural Route Number,
the Hospitel in 24 hours the Funeral ppletely filled	Medical Ce	one)	ician: To the best of my knowledger: On the basis of examination a and manner stated.	ge, death ind/or inv	occurred at the tim restigation, in my op	e, date and place, a inion, death occurre	nd due to the caus d at the time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)
Townith		29b. Signature and title of certifier  Aut Attac	le, mo		29c. License	2008		Date signed (Mon ay 13, 20	
Sta	te ar	30. Name and address of person who con ALAN G STAH  31. Date filed (Month, Day, Year)  MAY 1 3 2005	npleted cause of death (Item 23a)  M - D - 4 8 0 1  Registrar's Signature			LL DRIVE	E Ethie	OTT CIT;	1 21042

			1 - State of Maryland / Dep	eartment of Health and Mertificate of Death	lental Hygier		16240
	Physici		1. Decedent's Name (First, Middle, Last)  Georgia Lovely		· · · ·	Day Year	3. Time of Death
	/Medi Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	May	4c. County of Death	h
	Funeral		Hopkins Elderplus  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Edgemere  If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Baltimo:	re hplace (State or Foreign untry)
	Director		409–18–5589 1 □ M 2 🕪 F 83 Yrs.  Usual Residence of Decedent	Months Days Hours Min.	8. Date of Birth (Month, Day, Yea Oct 19,1921		KY
	rryland show	_	10a. State 10b. County 10c. City, Town or L	ocation Baltimore			10d. Inside City Limits
	the Maryland r 28e-f show notified at	Director	10e. Street and Number	10f. Zip Code	10g. (	Citizen of What Co	1 XYes 2 No untry?
	ath with		7904 Wallace	21222		USA	
900	ours after der rai', or iteme Examinar m	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Wildowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married  14. Was Decedent Ever in U.S. Armed Forces?  15. Was Decedent Ever in U.S. Armed Forces?  16. Yes, Give Year or Dates:	. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 2 TNo Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: W	
21215-0036	1 within 72 hours jiene r then "natural", Ir e Madical Exe	oletec	(Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of work DO NOT use retired)	ing	Kind of Business/I	Industry
212	ed with giene.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	Homemaker		wn Home	
Maryland	d la d	To Be	17. Father's Name (First, Middle, Last)  George Brown		e (First, Middle, Maide Smith	an Sumame)	
Aary	2 should and Men Is marke			ling Address (Street and Number or Run			
re,	s 1 and f Health item 27 other tr		20a. Method of Disposition 20b. Place of Disposition	amptoni or other place)	Date 20c.	boro TN  Location - City or 1	
Baltimore,	Pages tment of I tant: If it		'4 □Donation 5 □Other (Specify)  Bakers Fo	rge Cemetery May	11,2005 La	follette,T	V
Ba	permit. Departr Imports any inji	Ą	21. Signature of Funeral Service Licensee	22. Name and Address of Facility Charles L. Stevens Fu 1501 Fast Fort Ave. B	neral Home I	nc. 21230	
			23a. Part1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. ALTIC WE  Due to (or as a consequence of):	vs Dementio			4 years
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68760,	icate be executed physician and s the burial-transit	al Ex	resulting in death) Last Due to (or as a consequence of):				
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	w requires that been signed b should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		10	the cause of death?
Vital Records,	. 40 0	Completed			24a. Was an autopsy performed?	prior to c death?	topsy findings available ompletion of cause of
VIII	yeic an: is cellific director,	o Be	25. Was case referred to medical examiner?  1	Othor	me 5 Residence	6X Other (Spec	Assisted
n of	ing Ph Viter th uneral	lon: T	27. Manner of Death 1 Adatural 5 Pending 28a. Date of Injury (Month, Day Year) Injury	of 28c. Injury at Work?	28d. Describe how in		Living
Division	Dir	ertification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	M 1 Yes 2 No treet, factory, office	28f. Location (Street and City or Town, Sta	and Number or Ru ate)	ral Route Number,
	To the Hospitel within 24 hours a To the Funerel I completely filled	edical C	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, deal and manner stated.	th occurred at the time, date and place, nvestigation, in my opinion, death occurr	and due to the cause ed at the time, date a	(s) and manner as nd place, and due	stated. to the cause(s)
)	To the within 2 To the comple	Me	29b. Signature and title of certifier worksbrief in	29c. License number D 4 5 7 5 7		Date signed (Month	Day, Year)
	/		30. Name and address of person who completed cause of death (Item 23a) (Type Mattles McNabren 494	· Print) o Eastern Ave	Balt	110 Z	1224
	Sta Registi	ite ar	31. Date filed (Month, Day, Year) 32. Registrar's Signature MAY 1 3 2005	K)			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 2005 SHIRLEY JONES LIGONS -/Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death maryland General Hospi tal Bultimore N Shirley Ligens - Jones A 5. Social Seedrity Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, 01 · 27 · 1 Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 🗗 F Months Hours Director 212.46·5787 MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If term 27 is marked other than "naturel", or Items 23a or 28e-f show any injury or other traumatic event. The Martless Exercises. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits NIA Director MD BALTIMORE 1 No 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2748 ELLICOTI DRIVE 21216 Funeral USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by 3 ☐ Widowed 4 ☑ Divorced Specify: BLACK 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) BILLING SPECIALIST COLLECTIONS 121H GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) JOSEPH ABRAMS ROSA JOHNS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2748 ELLICOTI DR. KENDRA MANNING BALTO. MO 2/2/6 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State <sup>¹</sup> 4 □ Donation 5 □ Other (Specify) GREENMOUNT 105.12.05 BALTIMORE 21. Signature of Funeral Service License 22. Name and Address of Facility
VAUGHN C. GREENE FUNERAL SERVICE
5151 BALTO. NATE PIKE BALTO. MO 2 Van 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) The law requires that the death certificate be executed use as the burial-transit ardio that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 attending physician lan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Physici 4☐Pregnant at time of death 5 Other (specify) P.O. the a 9 Unknown 9 🗆 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ peq page 2 should 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has autopsy 2**X** No 1 Yes Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: P 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No Director: / 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral 6 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

0

State Registrar DR

R MADHAVA 31. Date filed (Month, E Pay 1 3 2005

MARYLAND 2. Registrar's Signature

2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GENERAL

HOSPITAL

AVE

2/201

BACTIMORG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Year **Physician** PM 4a. Facility Name (If not institution, give street and number) Noore 2005 /Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | (Month, Day, 11) Medica Eittes 7. Age (In yrs. last birthday)

52 Yrs. 9. Birthplace (State or Foreign **Funeral** Months 100 M 2□ F 215-54-4834 Usuel Residence of Decedent Director Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10d. Inside City Limits 10a State 10c. City, Town or Location or 28a-f show traumatic event, the Madical Examiner must be notified at ACTI MORE 1 Yes 2 No To Be Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Itams 23a 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian Black, While, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Caban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HEAUTH CARE TECHNICHAN Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Majden Sumame) KOVSTEK 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: if item 27 is any injury or other tra once. BATIMORE, MD 2/206 MIDLINE ROAD MOTHER 20c. Location - City or Town, State 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) ARBUTUS, MARYLAND ARBUTUS CEMETERY \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee BACTIMORE, MARY LAND 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician CORONARY ARTERY /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Litter to during Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner use as the burial-transit to the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, page 2 should be TENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an 1 Yes 2 No funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Matural 5 Pending within 24 hours after death. To the Funeral Director: A 1 🗌 Yes investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 29a. Certifier 🔁 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 05-06-2005 D0059107 M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ŋ

Registrar

State

Uma

31. Date filed (Month, Day, Year)

iberty Hts.

3 2905

Ave, TEFI, Baltimore, MD 21215

State of Maryland / Department / De	t of Health and Mental Hygiene 16-05 tas e of Death Reg. No. 2005 16243
Decedent's Name (First, Middle, Last)  Decedent's Name (First, Middle, Last)	2. Date of Death  Month  Day  Year
Physician Frances Louise Mosier	May 12, 2005 8:00 AM
Examiner	Town, or Location of Death  4c. County of Death
E Social Society Allieshop	sex Baltimore  1 Year   If Under 24 Hrs.   8 Date of Birth   9 Birthplace (State or Foreign
Director 220–62–3557 1□ M 2□ F 49 Yrs. Months	
Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
To a. State   10b. County   10c. City, Town or Location      Maryland   Baltimore   Essex	1 □Yes 3□No
Maryland Baltimore Essex  106. Street and Number 106. Z	Code 10g. Citizen of What Country?
g 8 g 329 Miles Road 21	221 U.S.A.
329 Miles Road  11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married  1 Never Married 2 Married  1 Never Married 2 Married	dent of Hispanic Origin? (Specify Yes or No- cify Cuban, Mexican, Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.
Se 5 1	2⊠No Specify: Specify: White
15. Decedent's Education 16a. Decedent's Usi	
(Specify only highest grade completed)  [Give kind of wind of	ark done during most of working
9800-15 1	ion Management Goddard Space Flt. Ctr
TO SET TO SE	18. Mother's Name (First, Middle, Maiden Surname)
Francis Pulaski	Anna Kuhar
E ខ្លុំ Craig Mosier, Sr. (Husband) 329 Miles	Road, Essex, Maryland 21221
20a. Method of Disposition  1 Burial 2 IXCremation 3 Removal from State  1 Burial 2 IXCremation 3 Removal from State  1 Donation 5 Other (Specify)  21. Signature of Fun all vice Lieuwee  22. Name a	me of Date 20c. Location - City or Town, State
1 Burial 2 X Cremation 3 Removal from State 1 Donation 5 Other (Specify)  1 Bury iew Crematory or Bayview Cremator	- , - ,
THE TO GO OF THE TOTAL STATE OF	d Address of Eacility Bruzdzinski Funeral Home, P.A.
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mo	Old Eastern Avenue, Essex, Maryland 21221
shock, or heart failure. List only one cause on each line.	Interval Between
Physician /Medical /Medical /Medical /Medical /Medical /Medical /Medical /Medical /Medical	sala Inony
Examiner A. S. P. I. T. G. T.	ron Premonitis I month
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	
Polytonia in the property of t	A A AVANINER
Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  d.	ORROVED BY MEDICAL EN THE
6876( diticate be g physicia as the buy ledlcal physicia physici physicia physicia physicia physicia physicia physicia physicia p	CERTIFICATION APPROVED BY MEDICAL EXAMINER
Power of the second of the sec	23d. Date of delivery
FFEMALE: 23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 2 □	regnancy Month Day Year
o. at year and an outdown	
Part II. Other significant conditions contributing to death but not resulting in the underlying	
cords signatures signa	1 ☐ Yes 2, ☐No 3 ☐ Probably 4 ☐ Unknown
The law requires the taw requires the taw requires the taw been signe page 2 should be completed by	24a. Was an autopsy autopsy findings available prior to completion of cause of
Comple	performed? death? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No
25. Was case referred to medical examiner?  10 Yes 2 Hospital:   Impatient 2 ER/Outpatient 3 D  25. Was case referred to medical examiner?  10 Yes 2 Hospital:   Impatient 2 ER/Outpatient 3 D  27. Manner of Death   Impatient 2 ER/Outpatient 3 D  28b. Time of Injury (Month, Day Year)  6:30 A M  28e. Place of Injury - At home, farm, street, factor building, etc. (Specify)	26. Place of Death (Check only one) Other: A Taliyation Home of Statistics of Tother (Country)
O 1 1 X Yes 2 1 1   Inpatient 2   ER/Outpatient 3   D 2 27. Manner of Death 28a. Date of Injury (Month, Day Year)   Injury 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	DA Carel. 4 Nursing Home 5 Aesidence 6 Other (Specify)  28c. Injury at Work?  28d. Describe how injury occurred
Sign and the state of the state	Work? X□Yes 2□No Motor vehicle accident
27. Manner of Death    The part   Par	
Street	I295 at Goddard Center
2 M Accident 3 Suicide 4 Homicide  3 Suicide 4 Homicide  4 Homicide  5 Could not be determined  5 Street  2 Macdident 3 Suicide 4 Homicide  5 Could not be building, etc. (Specify)  Street  2 Macdident 3 Suicide 4 Homicide  5 Cortifying Physician: To the best of my knowledge, death occurred (Check only onle)  2 Medical Examiner: On the basis of examination and/or investigation and manner stated.	at the time, date and place, and due to the cause(s) and manner as stated. , in my opinion, death occurred at the time, date and place, and due to the cause(s)
29b. Signature and title of centiler	29d. Date signed (Month, Day, Year)
20 Name and address of pales who completed source of death (Non-22s) (Time State)	H35593 MAY 12, 2005
30. Name and address of pelson who completed cause of death (Item 23a) (Type, Print)  DR JOHN LOH 1124 M	ACE AVE. BALTO., MD 2/22/
State 31. Date filed (Month, Day, Year) 82. Registrar's Signature Registrar MAY 1 3 2005	/

			1 - For State Registrar	State of	Marylan		artmen rtificat				ental Hy	giene Reg. No.	200	)5	16244
	Physici	an	Decedent's Name (First, Middle	e, Last)							2. Date of De Month	eath Day	Y	ear	3. Time of Death
	/Medic		FLORENCE	C.		LEIS	14				05	07	20	05	2:00Pm
	Examir	ier	4a. Facility Name (If not institution						Location			D	County of ALTI		o Er
			2.3 BROCKE  5. Social Security Number		RIVE '. Age (In yrs.				If Under		4D 2113	56			
	Funeral Director		212-49-3393	1 M 2 F	. Age (III yis.		Months	Days	Hours	Min.	(Month, Da	ay, Year)	و اد ی J	Cour	lace (State or Foreign try)
			Usual Residence of Decedent								12/1	7 / 1	76 0 0	21117	I CA
	irylar show	_	10a. State 10b. County		10c. Cit	y, Town or Lo								1	0d. Inside City Limits 1 ☐ Yes Z☐ No
	8a-f s	cto		IMORE		IIWO	NGS N	ILLL	S						1 Yes 2 No
	72 hours after death with the Maryland natural', or tems 23a or 28a-f show diest Examinat nat be notified at	Funeral Director	10e. Street and Number 23 BROOKEBU	RY DRIVE	ΔÞΨ	2B	10f. Zip	211	36			-	en of Wha A	t Cour	try?
	eath v	erai	11. Marital Status	12. Was Deced			Was Dage			igin? (Coo	offic Voc or No	US	4. Race -	Amaria	an Indian
	fter dea	E.	Never Married 2 Mar	ried 1 Tyes 2	es? X⊓No		If Yes, spec	ify Cuba	n, Mexicar	n, Puerto F	cify Yes or No Rican, etc.)		Black,		
93	al', o	by	3 ☐ Widowed 4 ☐ Divorced	If Yes Give			1□Yes X	<b>₽</b> ₩ No	Specify:				Specify:	BL	ACK
2-0	72 hc "natur	Completed		it's Education st grade completed)		(Give	dent's Usua kind of wo	rk done a	lurina mos	t of working	a	16b. Kir	d of Busin	ess/Ind	dustry
2		mpi	Elementary/Secondary (0-12) 12TH	2 YEARS	4or 5+)	life.	DO NOT us	e retired	)						
2	i filed withi Hygiene. othar than rant, Ina M		17. Father's Name (First, Middle,		>	NURS	DE /	BAN		CLLER	(First, Middle		CAL	_/_	BANKING
and	o d a d o e	To Be		LEISH						SELY		NAS			
Maryland 21215-0036	2 should by and Menta Is marked sumatic ev	F	19a. Informant's Name/Relations			19b. Mailis	ng Address	(Street a						te, Zip	<sup>Code)</sup> 21136
Š	s 1 and 2 should f Health and Mer itam 27 Is marke other traumatic		STACEY-ANN B	ROWN/DAUG	SHTER										MILLS, MD
Jre,	es 1 a of Hea fitam rothe		20a. Method of Disposition			lace of Dispo	sition (Nan	ne of ther place	9)	Da	ate	20c. Loc	ation - Cit	y or To	wn, State
E			Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5		tate KI	NG ME	MORI	AL E	K.	5/14	/2005	Bal	timo	re	Co., MD
Baltimore,	permit. Pag Department Important: any injury c		21. Signatur Tuneral Service	Licenson Control	W.										E 21207 MORE, MD
	1		23a. Farti. Enter he disease, o shock, or heart failure. List	complications that car	used the death										Approximate Interval Between
	Pnysician		Immedial Cause (Final disea or condition	Carry one cause on sp	5.42 £	-	درسا دو								Onset and Death
	/Medical		resulting in death)	Due to (o	r as a conseq		ع مرس							-	
	Examiner	ارا	Sequentially list conditions,	b											
	ped tisi	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (o	r as a consequ	uence of):									
/ _	be executed ician and burial-transit	Examine	that initiated events resulting in death) Last	c. Due to (o	r as a consequ	uence of);	-								
8760,	ate be executed physician and the burial-transit	ical				·									
89	tificate ng phy as the			0.											
Вох	law requires that the death certificate as been signed by the attending phys 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	ome of pregna		Ectopic pr	0000000				2	3d. Date of	delive	ry
	deat ed for	sicis	in the past 12 months? 1 ☐ Yes 2 ☐ No		nt at time of de		Other (sp.						Month		Day Year
P.0	at the de d by the etached	Phy	9 Unknown								T				
	res thai signed t be det	by	Part II. Other significant conditi	ons contributing to dea	ith but not resi	ulting in the u	nderlying ca	ause give	n in Part I.						e cause of death?
oro	v require been sig should b	eted									1	Yes 2	1NO 3[	_ FIOD	ably 4 Dorkhown
of Vital Records,	e law has b	Completed							-		24a. Was			to cor	osy findings available apletion of cause of
al	ate pag										1 ☐ Yes	2 No	1 🗆		2 🗆 No
Z.		o Be	25. Was case referred to medica examiner?	Hospital:				Othe			(Check only o		_		
of	Phys r this ral di	H-	1 Yes 2 No	28a. Date of	Injury	ER/Outpatier 28b. Time of		A	4 LI NU		e 5 Pesi 3d. Describe			Specify	)
on	nding th: : Afte	tior	1 Matural 5 ☐ Pendir 2 ☐ Accident investi	ng (Month,	, Day Year)	Injury	М	8c. Injury Work 1 🔲 Y	:? ∕es 2 🔲 i						
Division	Attai	iffice	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined   286, Place o	f Injury - At ho	me, farm, str	eet, factory	, office		2	Bf. Location (	Street and	Number o	r Rura	Route Number,
Ö	tal or s afte al Dir ed in	Certification;	4   Homicide	Dunding	g, etc. (Specify	Y)				ļ	City or To	wn, State)			
	To the Hospital or Attanding PI within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier 1 Certifyir (Check only one)	ng Physician: To the b Examiner: On the bas and manne	is of examinal	wiedge, deati tion and/or in	n occurred a vestigation,	at the tim in my op	e, date an inion, dea	d place, at th occurre	nd due to the d at the time,	cause(s) a date and	and manne place, and	r as st due to	ated. the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifie	r			29c	. License	number			29d. Date	signed (N	lonth, l	Day, Year)
)	~		) Cuts I	· NO				06	0817	2		05	109	105	
	'}	-	30. Name and address of person Robert L	who completed cause	of death (Item	23a) (Type,	Print) الناسة ال				81 B.				
	Sta Registr				gistrar's Signa	ture do	we			, ,	-				
		1		-0.6											

			1 - For Stete Registrer	State of Mary		rtment of H tificate of L			ene2 () () .	5 16245
	Physici /Medic		1. Decedent's Name (First, Middle, I	B.	Mark	Ji	۷,	2. Date of Death Month	Day Yes	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
	Examin		4a. Facility Name (If not institution, games of the Johns  5. Social Security Number 6	Hopkins Ho	pital	4b. City, Town, or Bul mo	Location of Death  2 Cit	8 Date of Birth	4c. County of D	eath Birthplace (State or Foreign
	Funeral Director		214-48-8714 Usual Residence of Decedent	½ M 2□F 57	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, 1) 1-29-194	(ear) 18 1	Maryland
	Marylan e-f ahow	tor	10a. State 10b. County  Maryland Anne A	arundel	e. City, Town or Loc Edge	ewater				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	h with the 23e or 280 81 be not	Funeral Director	10e. Street and Number 142 Duval Lane			10f. Zip Code 210	37	100	. Citizen of What USA	Country?
980	72 hours after death with the Maryland natural', or Items 23e or 28e-f ahow iteal Examinar must be notified at	þ	11. Marital Status  1 □ Never Married 2 🕅 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever Armed Forces? 1 Yes XXNo If Yes, Give Year or Dates:	11	Vas Decedent of Hi Yes, specify Cubar	spanic Origin? (Spanic Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Black, W	merican Indian, thite, etc. White
21215-0036	within ene. then "	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)	Education rade completed)  College (1-4or 5+)  2 years	(Give life. L	ent's Usual Occupa kind of work done d OO NOT use retired,	uring most of work	ing	b. Kind of Busine	ss/Industry Government
land	should be filed nd Mental Hygis marked other imatic event, L	To Be C	17. Father's Name (First, Middle, La Floyd B. Mart	st)			18. Mother's Name	hy M. Wi		
Maryland	nd 2 shou lith and M 27 is mari	_	19a. Informant's Name/Relationship Patricia A. Mart	(Type, Print)			nd Number or Rum	al Route Number, C vater, MD	ity or Town, State	e, Zip Code)
Baltimore,	Hear Hear othe		20a. Method of Disposition  1   ↑ Burial 2 □ Cremation 3  ↑ 4 □ Donation 5 □ Other (Spec	☐Removal from State	Db. Place of Dispos cemetery, crem		9)	Date 20	c. Location - City	or Town, State Maryland
Balt	permit. Pages Department of Important: If i any njury or one		21. Signature of Funeral Service Lic	ensee						eral Home MD 21037
8760,	cate be executed /Medical Examiner by sicien and surial-transit siths burial-transit	al Examiner	23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a cor	nsequence of):		due to m	or respiratory arrest	itis	Approximate Interval Batween Quest and Death AVS
P.O. Box 687	The law requires that the death certificate be executed attemption and site has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of print   1 University   2 University   4 Pregnant at time   9 Unknown	Fetal death 3 🗆	Ectopic pregnancy Other (specify)			23d. Date of o	delivery Day Year
	w requires that been signed by should be deta	ò	Part II. Other significant conditions	contributing to death but not	t resulting in the un	derlying cause give	n in Part I.	23e. Did tobac	-	to the cause of death?  Probably 4 □Unknown
Division of Vital Records,	r: The law requicate has been ; page 2 should	Completed						24a. Was an autopsy performe	d? prior t	autopsy findings available o completion of cause of es 2 No
of Vit	hysician: The this certificate al director, pag	To Be	25. Was case referred to medical examiner?  Yes 2 □ No	Hospital: Inpatient	2 ☐ ER/Outpatient	3□ DOA Othe	26. Place of Death	n <i>Check on one</i> me 5 ☐ Residend	e 6 □Other (S	pecify)
ion o	ding P	ation:	27. Manner of Death  1 Natural 5 ☐ Pending  2 ☐ Accident investigati		28b. Time of Injury	28c. Injury Work M 1 \(\supers	at ? es 2 ∐No	28d. Describe how	injury occurred	
Divi	or At	Certification;	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	28e. Place of Injury - A building, etc. (Sp.	At home, farm, stre	et, factory, office		28f. Location (Stree City or Town, S	t and Number or itate)	Rural Route Number,
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	Medical	one)	Physicien: To the best of my eminer: On the basis of exam and manner stated.	knowledge, death nination and/or invi	occurred at the time estigation, in my op	e, date and place, a inion, death occurre	and due to the caused at the time, date	e(s) and manner and place, and d	as stated. ue to the cause(s)
	V Viith	Σ	29b. Signature and title of certifier	Mr.	)	29c. License	number	29d	Date signed (Mo	nth, Day, Year) 2005
	.2.	'	30. Name and address of person wh	completed cause of death	(Item 23a) (Type, F	rint) Baltir	nove M	andand	2128	7
	Sta Registra		31. Date filed (Month, Day Agar)	3 2005 32. Recontrar's S	ignature	porte	)			

CPM 05-03256 Stanley Myers

State of Maryland / Department of Health and 1 = For Unpend Item 23a-b&27 per me G843 5-17-05 tas Certificate of Death	Mental Hygic	ene
1. Decedent's Name (First, Middle, Last)  Physician  Medical  STANLEY M. MYERS	2. Date of Death Month May	10, 2005 13:24 M
Examiner  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Dear  Union Memorial Hospital  Baltimore		4c. County of Death
Funeral Director 5. Social Security Number 6. Sex 10 Months Days Hours Min		(Year) 9. Birthplace (State or Foreign Country)
Usual Residence of Decedent  10a. State  10b. County  10c. City, Town or Location		10d. Inside City Limits
To street and Number  10e. Street and Number  10f. Zip Code	100	1 <b>K</b> yes 2 □ No g. Citizen of What Country?
# E B IS MOUNTAINTOP 06513		USA
If Yes, Give 1 ☐ Yes 2 No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc.
15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of wo life. DO NOT use retired)  17 TH GRADE  18 STUDEM	orking 16	6b. Kind of Business/Industry
TO DESCRIPTION OF THE PROPERTY		COUEGE
Elementary/Secondary (0-12)  To purply  To p	me (First, Middle, Ma A MYERS	
19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Right Street Street Street and Number or Right Street S	ural Route Number, (	City or Town, State, Zip Code)
PATRICIA FRAZIER  20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  1 Burial 2 Cremation 3 Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other place)  8 EAVERDALE MEM. 05. I  21. Signal are of Fune (a) Service Licensee  22. Name and Address of Facility  22. Name and Address of Facility  23. Name and Address of Facility  24. Date of Disposition (Name of cemetery, crematory or other place)  25. Name and Address of Facility  26. Name and Address of Facility  27. Name and Address of Facility  28. Name and Address of Facility  29. Name and Address of Facility  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Name and Address of Facility  27. Name and Address of Facility  28. Name and Address of Facility  29. Name and Address of Facility  29. Name and Address of Facility  20c. Name and Address of Facility		Oc. Location - City or Town, State
4 Donation 5 Other (Specify)  22. Name and Address of Facility  August 1 of Specify 22. Name and Addre	17.05 N	EW HAVEN, CT.
OTSI DIFLIO. INFILE PIRE	BALTO. MI	21229
23a. Part1. Ente (the disease, or complications that caused the death. Do not enter the mode of dying, such as cardial shock, or hear failure. List only one cause on each line.  Physician    Physician	c or respiratory arres	t, Approximate Interval Between Onset and Death
/Medical resulting in death)  Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		
fi any, leading to immediate cause. Enter Underlying  The part of		
de dical Estate de examination de la constant de la		
So of the past 12 months?  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  If FEMALE: 23c. If yes, outcome of pregnancy 1		23d. Date of delivery Month Day Year
O early the state of the state	23e. Did toba	cco use contribute to the cause of death?
The law require te has been situated and age 2 should the law require to the part of the law required and age 2 should the law is a second to the law is a secon	1 ☐ Yes 24a. Was an	2 Probably 4 ☐Unknown  24b. Were autopsy findings available
The second of th	autopsy performe	prior to completion of cause of death?
25. Was case referred to medical examiner?  1 💆 Yes 2 🗆 No  26. Place of Death Hospital: 1 🗀 Inpatient 2 🛣 ER/Outpatient 3 🗆 DOA Other: 4 🗀 Nursing F	ath (Check only one)	ce 6 □Other (Specify)
27. Manner of Death 27. Manuer of Death 28a. Date of Injury 48b. Time of Injury 4b. Time of Injury	28d. Describe how	
To long the state of the state	28f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)
29a. Certifier (Check only one)  29b. Signature and biffe of certifier 29b. Signature and biffe of certifier 29c. License number  29c. License number	and due to the caus	se(s) and manner as stated.
one)  and manner stated.  29b. Signature and title of centifier  29c. License number		
29b. Signature and the of centrifier 29c. License number	29d	. Date signed (Month, Day, Year)
OCME	29d	May 11, 2005
OCME		

			1 - For State Registrar	State of Maryland	d / Depa <i>Cer</i>	artment rtificate	of He	ealth a leath	ınd Me		iene	005	16247
	Physici	an	Decedent's Name (First, Middle, Last,     Robert Frederick							2. Date of Dear	-	20ď5°	3. Time of Death
	/Medio		4a. Facility Name (If not institution, give			4b. City, To	own, or L	ocation o	f Death			inty of Death	9:04р м
			Holy Cross Hospi					Spri				ntgome	
	Funeral Director		5. Social Security Number 6. Sec 219-36-9756	7. Age (In yrs. In 64	ast birthday) Yrs.	If Under 1 Months [	Days	If Under 2 Hours	Min.	3. Date of Birth	1 <sup>y</sup> 94/0	9. Birth	place (State or Foreign Trigton DC
	and		Usual Residence of Decedent  10a. State 10b. County	10c. City	/, Town or Lo	cation							10d. Inside City Limits
	Maryl a-faho	tor	MD Montgo		Silver		g						1 Taryes 2 □ No
	h with the 23a or 28a 81 te not	Funeral Director	10e. Street and Number 12828 Holdridge	Rd.		10f. Zip C		0906		1	0g. Citizen USA	of What Cou	ntry?
980	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-1 ahow any injury or other traumatic avant, its Medical Examination until the notified at ODGE.	þ	11. Marital Status  1 ☐ Never Married 2 ★ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2€ No If Yes, Give Year or Dates:	1	Vas Deceder f Yes, specify		anic Orig Mexican, Specify:	gin? (Spec , Puerto Ri	ify Yes or No- ican, etc.)		Race - Ameri Black, White, ecity: Wh	
Baltimore, Maryland 21215-0036	within 72 ho	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	(Give life. L	lent's Usual ( kind of work of DO NOT use	Occupati done dui retired)	on ring most	of working	7		f Business/In	
g 5	illed v Hygie other t	Be Co	17. Father's Name (First, Middle, Last)	3+	Car	penter	1	8. Mother	r's Name (	First, Middle, M		struct	ion
ylan	ould be Mental arkad atic av	To B	Frederick Monagh							izabeth			
, Mar	and 2 sh salth and 27 Is m ar traum		19a. Informant's Name/Relationship (Ty Audrey Monaghan		19b. Mailin 1282	g Address (S 28 Ho1	drid	ge R	d. Si	Route Number 1ver S	City or Too pring	wn, State, Zip MD 20	906
more	Pages 1: nent of He int: If itan		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	ace of Dispos emetery, crem esapeal	natory or othe	er place)	ry	05 <b>-</b> 09	te 9 <b>–</b> 2005		on - City or To sville	
Balti	permit. Departn Imports any inju		21. Signature of Funaral Service License	1111297	22.	Rapp	Fune	ral	& Cre	emation er Spri	Serv:	ices	0
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the death	. Do not ente	er the mode o	of dying,	such as o	cardiac or	respiratory arre	est,	0 2091	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Congestive		Failu	re						Onset and Death
	Examiner		Sequentially list conditions,	Due to (or as a consequ Acute Renal		ıre							
	ted :	Examiner	in any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of the consequence of t	•								
o,	icate be executed physician and s the burial-transit	Exar	that initiated events resulting in death) Last	Due to (or as a consequ									
68760,	icate b physic s the bi	dical											
.O. Box (	The law requires that the death certiticate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnar 1 □Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3 🗌	Ectopic pregr Other (speci						Date of delive	ery Day Year
Ω.	quires that n signed by ald be deta	by	Part II. Other significant conditions con	tributing to death but not resul	lting in the un	derlying caus	se given	in Part I.			acco use co		ne cause of death?
Records,	The law requir sate has been si page 2 should	Completed								24a. Was ar autopsy perform	/	b. Were auto prior to cor death?	psy findings available mpletion of cause of
Vital		Be Co	25. Was case referred to medical				2	6. Place	of Death (	1 ☐ Yes 2	No No	1 🗆 Yes	2 No
ot O	Phyaic this ce al dire	۵,	I Les XX		R/Outpatient		Other:			5 Reside			/)
ion	utanding death. ctor: Atter y the funer	ation	27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c.	Injury all Work? 1  Ye:	t s 2 □ N		d. Describe ho	w injury occ	urred	
Division of	e Hospital or Attano 24 hours after death a Funaral Diractor: etely tilled in by the	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)	ne, farm, stre	et, factory, of	ffice		281	f. Location (Str City or Town		mber or Rura	l Route Number,
	To the Hospital or Attanding Physician: whin's 4 hours alter deals, the his certitic To tha Funaral Director: Attent his certitic completely tilled in by the funeral director,	edical	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of my know er: On the basis of examination and manner stated.	rledge, death on and/or invi	occurred at t estigation, in	he time, my opin	date and ion, death	place, and occurred	d due to the ca at the time, da	use(s) and te and plac	manner as st e, and due to	ated. the cause(s)
	To the within 2 To tha complete	Σ	29b. Signature and title of confifier	re la			DO06	umber 2520		29	-	ned (Month, 15-2005	Day, Year)
	b		30. Name and address of person who co.  Maria Darbella 1	mpleted cause of death (Item 500 Forest Gle	23a) (Type, P en Rd.	Print) Silve	r Sp	ring	MD 2	20910			
	Sta Registr		31. Date filed (Month, Day, Year) MAY 13 20	32 degistrar's Signatu	f for	whi							

			1 - State Registrar	state of Maryland		artment tificate			ind Ment	al Hygier	600		6248
	Physic /Medi Examir	cal	Decedent's Name (First, Middle, Last)     Lela Mar H     4a. Facility Name (If not institution, give stre	et and number)		4b. City. 7	Fown or I	Location of	N	lay o		Year 0	Time of Death  3 52 PM
		IGI	5. Social Security Number 6. Sex	7. Age (In yrs. lass	t hirthday)	80 If Under	1/7	MOVE If Under 2	2		N/A	A	(State or Foreign
	Funeral Director		407-20-5220 1 ☐ M	2ĂF 82	Yrs.	Months	Days	Hours	Min. Fe	ate of Birth fonth, Day, Yea b 8, 19	23	Country) Kentuc	
036	should be filed within 72 hours after death with the Maryland nd Mental Hygiene. It marked other than "natural", or Itams 23a or 28a-f ehow umatic event, the Macheal Exambles must be inclifted at	ctor	10a. State 10b. County MD Baltimon	10c. City, T	own or Lo	cation Lans	down	e					nside City Limits ☐ Yes 2 No
		Dire	10e. Street and Number 105 Fifth Avenue			10f. Zip		1007			Citizen of Wh		
		by Funeral Director		Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2Æ No If Yes, Give Year or Dates:		Was Decede f Yes, speci	ent of His fy Cuban	1227 panic Origin, Mexican, Specify:	in? (Specify Y Puerto Rican		14. Race -	State American Inc White, etc. White	dian,
21215-0036		Completed	15. Decedent's Education (Specify only highest grade of Elementary/Secondary (0-12)		(Give life. [	lent's Usual kind of work DO NOT use Homema	k done du e retired)		of working	16b.		ness/Industry	
Maryland		To Be C	17. Father's Name (First, Middle, Last) Henry Clay Sawyer					Jai	nie Ly	nn Sets	er er		
Mai	rau rau		19a. Informant's Name/Relationship ( <i>Type</i> , Shirley Mae Braswel							te Number, City Linthic			
nore	ages 1 and of He t: If itam	,	20a. Method of Disposition  ☐ Burial 2 ☐ Cremation 3 ☐ Rem	20b. Place	e of Dispos etery, crem	sition (Name natory or oth L Ceme	e of her place,	)	Date 5-14-2(	20c.	Location - Ci	ity or Town, S	
Baltimore,	permit. Pages 1 and Department of Healtl Important: If itam 23 any injury or other tonce.		'4 □ Donation 5 □ Other (Specify)  21. Sgnature of Fundal Server License	DONIUS	O 22	. Name and	Address	of Facility	mbrose	Funera Arbu		e, Inc	
Vi.	Anysician /Medical Examiner		Approximate Interval Batween Onset and Death disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and Death of the cause										val Between
		er	Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last  Due to (or is a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):							21			
8760,	the death certificate be executed y the attending physician and iched for use as the burial-transit									21	hours		
9	rtificate ng phys as the	Aedical	d. Z	-0119	1								
О. Вох	that the death certific ed by the attending pl detached for use as t	Physician/Me	23b. Was decedent pregnant in the past 12 months?  1							23d. Date of delivery  Month Day Ye			Year
Records, P.	w requires that the been signed by should be detact	by							2	3e. Did tobacco use contribute to the cause of death?  1 □ Yes 2 ⅣNo 3 □ Probably 4 □Unknown			
	Hospital or Attanding Physician: The law 4 hours after death. At hours after death of the this certificate has bely filled in by the funeral director, page 2 stell filled in by the funeral director, page 2 stell filled in by the funeral director.	Completed							_	4a. Was an autopsy performed? Yes 2 \( \sqrt{N} \)	prio dea	or to completic	
		on: To Be	25. Was case referred to medical examiner?  1  Yes 2 No Hosp  27. Man of Death 1 Natural 5 Pending	Outpatient b. Time of Injury	Time of 28c. Injury at 28d. Describe how injury occurred								
Division		ertification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, fact building, etc. (Specify)					M 1 ☐ Yes 2 ☐ No					e Number,
		edicai C	29a. Certifier 1 Certifying Physicia (Check only one) 2 Medical Examiner:	in: To the best of my knowled On the basis of examination and manner stated.	dge, death and/or inv	occurred at estigation, i	t the time n my opir	, date and nion, death	place, and du occurred at t	e to the cause( he time, date ar	s) and manno nd place, and	er as stated. I due to the ca	ause(s)
)	To the within 2 To the complet	Me	29b. Signature and title of cedition	AMO:		29c.	License r	77	88	29d. D	ate signed (A	Month, Day, Y	(ear) 2005
	10		30. Name and address of person who complete. M. Favasar Mb	eted cause of death (Item 23	a) (Type, F	Print)	Ba	Himo	12,1	10 2	122	5	
	Sta Registr		31. Date filed (Month, Day, Year) MAY 1 3 2005	Z. Registrar's Signature	Spar	K)					-		

			1 - For State Registrar	State of Ma	arylan	•	artment rtificate			d Mental H	ygien Reg. N	211	15	16249
	Physici		1. Decedent's Name (First, Middle, La A •		MOGOL			2. Date of I Month MAY		ay ) 20	Year 05	3. Time of Death 12:28 P M		
	/Medic Examin		4a. Facility Name (If not institution, give street and number)			4b. City, Town, or Location of Death						c. County		1
			CATERED LIVING	OF PIKESVI	LLE			ΓΙΜΟRΙ				N/	Α	
	Funeral Director		213-10-1161	Sex 100 M 2□F 7. Ag	91	last birthday) Yrs.	If Under 1 Months		Under 24 I Hours N	Hrs. 8. Date of 8 (Month, 1)	Day, Yea	913	9. Birthp Coun	lace (State or Foreign try)
	land ow		Usual Residence of Decedent  10a. State  10b. County		10c. City	y, Town or Lo	cation						1	0d. Inside City Limits
	Mary F sh	tor	MD N/A		БА	LTIMOR	E							1.□Yes 2□No
	th the	Director	10e. Street and Number				10f. Zip C	Code			10g. C	itizen of W	hat Cour	ntry?
	23a c	ral	7218 PARK HEIGH					1208				USA		
	er dez	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		.S. 13.	Was Decede f Yes, specif	ent of Hispa fy Cuban, N	nic Originî Mexican, Pi	(Specify Yes or luerto Rican, etc.)	No-		- Americ c, White,	an Indian, etc.
36	irs aft	by F	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 XX If Yes, Give Year or Dates:	No		1 □ Yes 2	XNo S	Specify:			Specify:	W	HITE
21215-0036	72 hours after death with the Maryland natural', or Itams 23a or 28e-f show dical Examinet must be notified at		15. Decedent's E	ducation		16a. Dece	dent's Usual	Occupation	n n	working	16b.	Kind of Bu	siness/Ind	dustry
218	thin 7 e. an "n Ned	To Be Completed	(Specify only highest gr Elementary/Secondary (0-12)	College (1-4or 5	5+)	life. i	kind of work DO NOT use	retired)	ng most of	working		. IDAIT O	T 110 50	
7	led wi ygien har th		12			SA	LES	10	14-4bd-	Name of Time Added		URNIT		
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked othar than "natural", or Itams 23a or 28e-f show any injury or othar treumatic avant, the Medical Evaniner must be notified at one.		17. Father's Name (First, Middle, Last MORRIS	7	МО	GOL		10.	MARY	Name (First, Mida	ie, Maide		" TSCH	UL
lary	shou and N Is mai		19a. Informant's Name/Relationship							Rural Route Nun				
	and 2 ealth m 27 har tr		LORRAINE MOGOL/SE	POUSE	100h D				TS AV	E; BALTI		·	212	
Baltimore,	Pages 1 nent of H int: if ita iry or ott		20a. Method of Disposition  1XXBurial 2 ☐ Cremation 3 [		C	lace of Dispo emetery, crer	natory or oth	ner place)				Location -		
Εijμ	iit. Pa artmer ortant injury		* 4 □Donation 5 □ Other (Special Service Lice		BIN	AI ISR				12/2005		LTIMO		
Ba	Depa Impo any ii		Roleto/o	Trons			8900 I	REIST	ERSTO	OL LEVIN	SON IKES	& BRC VILLE	S.,I	NC. 21208
h	*		8900 REISTERSTOWN RD; PIKESVILLE, MD 21208  23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and Death											
į	Physician		Immediate Cause (Final disease or condition resulting in death)  A 5 DI VA TON P N E UN ON 1 A  Due to (or at a consequence of):									The second secon		
B	/Medical Examiner													
d		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.											
	d ansit	Examiner												
ο, Ο	e exection and an arrial-tr													
8760,8	death certificate be executed e attending physicien and id for use as the burial-transit	dical												
θ	leath certific attending p	/Mec	IF FEMALE:	23c. If yes, outcome	of pregna	incv						23d. Date	of doing	
Вох	atten atten I for u	cian	23b. Was decedent pregnant in the past 12 months?  1							Month Day Year				
0	t the d by the achec	hysi	9 Unknown										ŀ	
S, D	w requires that the de been signed by the s should be detached	by Physician/Medical	Part II. Other significant conditions	contributing to death b	ut not resu	ulting in the u	nderlying cau	use given ir	n Part I.					ably 4 Danknown
Vital Record	requii	Completed	24a. Was an autopsy perform											
3ec	0 00	mpl								topsy	prior to completion of cause of death?			
la	n: Th ficate or, pay	e Co	25. Was case referred to medical	T				26	Place of	1 ☐ Yes		0 1	☐ Yes	2□ No
₹	Phyaician: this certific ral director,	To Be	examiner?	Hospital: 1 ☐ Inpatie	ent 2 🗆	ER/Outpatien	t 3 DOA	Othor		g Home 5 ☐ Re		6 ∏Othe	r (Specifi	()
of	ding Phyaician: The I. h. After this certificate ha funeral director, page		27. Manner of Death	28a. Date of Inju (Month, Da	ry	28b. Time of		c. Injury at Work?		28d. Describ				
Sior	Attanding or death. ector: After by the fune	atic	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		M 1 Yes 2 No									
Division	= e = c	Certification;	3 Suicide 6 Could not to determined	ome, farm, str v)	me, farm, street, factory, office  28f. Location (Str. City or Town,					treet and Number or Rural Route Number, n, State)				
	To the Hospital or Attan within 24 hours after deat To tha Funaral Director: completely filled in by the		29a. Certifier 1 Certifying P	hysician: To the best	of my kno	wledge, death	occurred at	t the time, o	date and pl	ace, and due to th	e cause(	s) and mar	ner as st	ated.
	the Ho nin 24 tha Fu npletel	ledical	one)	miner: On the basis of and manner sta		tion and/or in				ccurred at the tim				
	To Yeld	Σ	29b. Signature and title of certifier			, c		License nu		- 616		ate signed	C) (-	vay, 1881)
	lia		Jam Wellewww Mts DOC51896 5/10/05  30. Nature and address of person who completed cause of death (Item 23a) (Type, Print)  Lower Mankon 3635 OLD COURT DE SPECIO "21208"									415		
	3		Marce and address of person wild	201 36	30	OL8	( Oel	P	00	STE	210	54	21	208
	Sta		31. Date filed (Month, Day, Year)	32. Regi <b>e</b> tr	ar's Signa	ture /	Soul!	1	, , , , , , , , , , , , , , , , , , ,					
	Registr	ar	MAY 1	3 ZUUD JULA	gev-	10. 1	7							

31	33		Please	Type or Print				-	•		
			1_ For State	State of Man				Mental Hygi	ene () () 5	16250	
		on	Registrar		Ce	rtificate o	f Death	Re	g. No.	104200	
	Physici		Decedent's Name (First, Middle, La	•				Date of Death     Month	Day Year	3. Time of Death	
	/Medio		RONALD WILLIAM						005	04:25 a.™	
	Examir		4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town,	or Location of Dea	ıth	4c. County of Dear		
			3020 Edmondson Av	enue, 1st f	loor	Baltim	ore City			A	
	Funeral		5. Social Security Number 6. S	ex 7. Age (li	n yrs. last birthday)		r If Under 24 Hr		Year) 9. Birt	hplace (State or Foreign	
	Director		218.36.1004	18 M 2 L F 6 E	) Yrs.			01-10.10	40	MP	
	and w		Usual Residence of Decedent  10a. State 10b. County	10	Oc. City, Town or Lo	ocation				10d. Inside City Limits	
	l sho	5	MD NI		BALTIMOR	_				1 Yes 2 No	
	the A	Director	10e. Street and Number		JII III III III III III III III III III				6111 1 6		
	with B or	ä		N AVENUI	_	10f. Zip Code	_	10	g. Citizen of What Co	untry?	
	be filed within 72 hours after death with the Maryland hat Hygiene. ad other than "naturel", or Items 23e or 28e-1 show event, the Modical Examinat must be notified at	Funeral	3020 EDMONDSO	12. Was Decedent Eve		212		Sanat Van an Na	USA	dan India	
	lter d	Ë	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces?	Armed Forces?		ban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Ame Black, Whit	e, etc.	
39	irs af	by F	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🔼 N	Specify:		Specify: BL	ACV	
Ö	2 hou	ed	15. Decedent's Ed	ducation	16a. Dece	dent's Usual Occ	upation	1	6b. Kind of Business/		
75	nin 72 n "nat	Completed	(Specify only highest gra	de completed)	(Give	kind of work don DO NOT use retir	e during most of we	orking	ob. (4.1.0 o) buoillood	madatiy	
5	d within giene.		12-TH GRADE	College (1-4or 5+)	MAIN	TENANC	E MAN		JANHORIA	L	
ष्ट	e filed within al Hygiene. other than vent, the Ma	a)	17. Father's Name (First, Middle, Last)				18. Mother's Na	ame (First, Middle, M			
<u>a</u>	Mental Mental rked c	To B	WILLIAM R. NIP	PFR			REGIN	A L. CUF	2RV		
Maryland 21215-0036	2 should be and Mental le marked ( aumatic ev	_	19a. Informant's Name/Relationship (		19b. Mailir	ng Address (Stree			City or Town, State, 2	(ip Code)	
	5 4 5 E		STEPHANIE THOMP	SON	3020	EDMON	DSON A	E. BALTO	. MD 213	223	
<u>e</u>	of Heal		20a. Method of Disposition	2	20b. Place of Dispo				Oc. Location - City or	Town, State	
Ĕ	permit. Pages Department of I Importent: if Ite any injury or of		1 ☐ Burial 2  Cremation 3 ☐  `4 ☐ Donation 5 ☐ Other (Specify		3REENMO			16.05 B	ALTIMORE	MD	
Baltimore,	permit. Pa Departmer Importent: any injury		21. Signature of Funeral Service Licer	A TOTAL OF THE PARTY OF THE PAR				UNERAL SE		, 1.0	
m	Depar Depar Impo		Vaushn C	1	VA SI	IUGHN C. ( 51 BALTO	AKEENE F	e, baud.	WD 21229		
				plications that caused the	death. Do not ent	er the mode of dy	ing, such as cardia	ac or respiratory arres	at,	Approximate	
	that the death certificate be executed  Weddinar  How a second of the attending physician and detached for use as the burial-transit		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Athor Scientic Candio Vascular disease.  Due to (or as a consequence of):								
		ner	Sequentially list conditions, any, but it is to minimize the cause. Enter Underlying cause. Enter Underlying Cause (Disease or injury that initiated events  c.								
		Examiner									
o,	an ar rial-t										
1760,		ca	d.								
68	ntifica ng ph as th	Physician/Med	IS ESIAN S								
Вох	endii r use	N/UE	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1						23d. Date of deli	very	
	deal	SICI							Month	Day Year	
P.O.	at the by th	hy	9 🗆 Unknown								
	The law requires that the death certifica lie has been signed by the attending ph age 2 should be detached for use as th	by F	Part II. Other significant conditions of		ot resulting in the u	nderlying cause g	iven in Part I.	23e. Did toba	cco use contribute to	6.	
Vital Records,	w requir been si should	Completed	24a. Was an						2 □ No 3 □ Pro	2 No 3 Probably 4 Nunknown	
ပ္ထ	awre is be								24b. Were au	topsy findings available	
ď	The lav	Eo						autopsy performe 1 X Yes 2	d? death?	ompletion of cause of 2□ No	
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0	g Phys er this eral dir	Certification; T	27. Manner of Death	28a. Date of Injury	28b. Time of	28c. Inje	ury at	28d. Describe how		"77	
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	in 24 he Fi	edical	one) 24 Medical Exam	niner: On the basis of exa and manner stated.	umnation and/or in	vestigation, in my	opinion, death occ	urred at the time, dat	e and place, and due	to the cause(s)	
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1	)		30. Name and address of person who	completed cause of death	(Item 23a) (Type,	Print)	one C+	- D 7 · *		1.010	
V			LING LI	min		TTT L6	un Stree	t Baltimo	ore, Maryl	and 21201	
	Sta		31. Date filed (Month, Day, Year) MAY 1 3 200	32. Registrar's		E)					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Vear **Physician** Mai /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner tora stnut 12 8. Date of Birth Month, Day, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** Days Hours 218-32-6400 Min 1□M 200 F Yrs. Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a. State 10b. County ir than "natural", or Itams 23a or 28e-f show the Nedical Examiner must be notified at 1 Yes 2 No Director M Forest 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5ac 21057 Pages 1 and 2 should be filed within 72 hours after death Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 11 Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No 21215-0036 Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Is markad othar than Elementary/Secondary (0-12) College (1-4or 5+) 1 a 18. Mother's Name (First, Middle, Maiden Sumame) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be Hurle Kubu Howel ပ 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, (rint) · spouse 524 out Hill Kd f Health itam 27 I Chest William 1000191 Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ita
any injury or ott 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Bel Air Monorial Gardens 5-13-05 Bel Air ' 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility HCL, MD 21050 21. Signature of Funeral Service L EVANS FUNERAL CHAPEL-BEL AIR 3 NEW PORT DR. 19the Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediete Cause (Final PARS Physician 11 ETASTALIC disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown signed by t d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 25 No 2 □ No 1 TYes 1 ☐ Yes Hospital or Attanding Physician: 26. Place of Death (Check only one) 25. Was case referred to medical examiner Other: 4 Nursing Home Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 □Other (Specify) 1 Yes 2 No Certification: To his 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of After 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death Diractor: 2 Accident the 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Mucharle

Registrar
DHMH 17 Rev 1/2001

State

**ORIGINAL** 

RO

Boltimore

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AUERBACH

31. Date filed (Month, Day, Year)

9110 Philadelphia

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year. 7:25 P N **Physician** NORRIS HAROLD MAY 2000 /Medical 4a. Facility Name (If not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death Examiner BALTIMORE HUSPITAL CENTER HARBOR If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Yea 3-24-1932 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Months 1**₹** M 2□ F 240-44-9969 73 Dunn, **Director** Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show The Medical Examiner must be notified at MD N/A Baltimore 1 Tx Yes 2 □ No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 3641 MacTavish Ave 21229 U.S.A. filed within 72 hours after death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 220No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 10 Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) than College (1-4or 5+) Elementary/Secondary (0-12) Nursing Supervisor Spring Grove Hospital h and Mental Hygie 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If itam 27 Is markad oth any injury or other traumatic event 90x8. Isaac W. Norris Velma Holt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Patricia Norris/Wife 3641 MacTavish Ave Baltimore MD 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1☐ Burial 2 Cremation 3 ☐ Removal from State Barview Crematory 3-12-2005 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility Ambrose Funeral Home, Inc 1328 Sulphur Spring Rd., Arbutus MD 21227 21. Signature of Funeral Service Licer Approximate Interval Between Onset and Death Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final CORONARY 15 years **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Attending Physician: The law requires that the death certificate be executed nding physician and Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 16s 2 No 3 Probably 4 Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe KIDNE 2 No CHRONIC 2 No 1 Tes this certificate funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 Umpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 5 Pending 1 GNatural 1 Yes 2 No death. investigation 2 ☐ Accident Diractor: filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide hours after Hospital or within 24 hours a To the Funeral D 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. 29c, License number RESOO O 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RESIDENT Kaman Sraff PHYSICIAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
HARRAP HUCPITAL CENTER, 300) SOUTH HANDUER STREET, BALTIMORE, MD HARBOR 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

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21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther then "naturel", or fteme 23a or 28e-f show ther, the Medical Examiner must be notified at	d by	3 ☐ Widowed 4 ☐ Di	vorced	Year or Date	s:		TILL THS A	ZIZI NO	<i>Зреспу.</i>			5,	ресify: WП.	
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19	Physician		Immediate Cause (Final	e. List only o	ne cause on eac	h line.	on to G	ancis	1176	110	06	the.	Vin	21	Interval Between Onset and Death
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	15		30 Name and address of	person who	ompleted cause	of death (Item	23a) (Type,	, Print)	no	utju	RA	tosput	-al	Cent	tated. o the cause(s)  Day, Year)  2005
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	/Medic	al	Ja 4a. Facility Name (If not institution, give	mes William Pe	each	4b. City. Town, or	r Location of Death	MAY	4c. County of De	
	Examin	er		ALTHICARE			TIMORE		None	
	Funeral Director		253 24 9131	7. Age (In yrs. Ia	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Apr 6,	Year) (	irthplace (State or Foreign Country) Georgia
	and and		Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Loc	cation				10d. Inside City Limits
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Ž	should nd Men marke umatic	ဥ	19a. Informant's Name/Relationship (7)	· · · · · · · · · · · · · · · · · · ·	19b. Mailin	g Address (Street :	and Number or Rura		City or Town, State	. Zip Code)
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Baltimore,	permit. Page Department Importent: fl eny injury or		21. Signature of Funeral Service Licens	with MOIC						mily FH Inc. y, MD 21043
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	ications that caused the death. ne cause on each line.	Do not ente	er the mode of dyin	ng, such as cardiac o	r respiratory arre	st,	Approximate Interval Between Onset and Death
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P.O. Box	w requires that the death certif been signed by the attending should be detached for use a	by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnan 1 ☐ Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of dea 9 ☐ Unknown	death 3	Ectopic pregnancy Other (specify)	1		23d. Date of d Month	elivery Day Year
	that the hold by detact	y Ph	Part II. Other significant conditions co	ntributing to death but not resul	lting in the ur	nderlying cause giv	en in Part I.	23e. Did tob	acco use contribute	to the cause of death?
rds	quires en sign							1 ☐ Ye	s 2□No 3□I	Probably 4 Unknown
Division of Vital Records,	e la has	Completed						24a. Was an autopsy perform	r prior to	
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no	ding F h. After funer	tion	27. Manner of Death  1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor M 1	k? Yes 2 □ No	Zod. Describe no	w injury occurred	
Divisi	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)	me, farm, stre	et, factory, office		28f. Location (Str. City or Town,		Rural Route Number,
	Hospitel or 24 hours afte Funeral Dir Blely filled in I	edical C		sician: To the best of my know ner: On the basis of examination						
	To the within 2 To the complet	Me	29b. Signature and title of certifier	1	۸. ۵	29c. Licens			d. Date signed (Mo.	_
			I Langa Kniv	stirenica,	14D	P1	7602	1	1A4,12H	1,2005
2	7		30. Name and address of person who colored LARYSA WHINTKIE	ompleted cause of death (Item NC2, 900 CATO	23a) (Type,	Print) ENUE, B	BALTIMOR	E, MAR	42AND	21229
	» Sta Registr	á	30. Name and address of person who of LARYSA WWINTKIE I/ 31. Date filed (Month, Day, Year) MAY 1 3 2	32. Augistrar's Signatu	& A	nade				

DHMH 17 Rev 1/2001

PEACH , JAMES NILLIAM

			State of Maryland / D  1 - Stete Registrar AMEND ITEM #8 PER FH G844 6	epartment of Health and M Gertificate of Death	lental Hygier	4005 16255
	Physici		Decedent's Name (First, Middle, Last)	drotti	2. Date of Death May 11,	3. Time of Death 12:55 AM
	/Medic Examin		4a. Facility Name (If not institution, give street and number)  Lorien Nursing & Rehab	4b. City, Town, or Location of Death Columbia		4c. County of Death Howard
	Funeral Director		002 12 1077	nday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea Jan. 24,	1923 9. Birthplace (State or Foreign Country) Chicago, IL
	Maryland f show	or	Usual Residence of Decedent			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	vith the l	Direct	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?
ဖွ	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or Itams 23e or 28e-f show any injury or other traumatic event. It e Madical Exertities must be notified at once.	Completed by Funeral Director	6334 Cedar Lane  11. Marital Status  1 Never Married 2 Married 3 Midowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give X Year or Dates:	21044  13. Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto  1  Yes 2 No Specify:	ecify Yes or No- Rican, etc.)	USA  14. Race - American Indian, Black, White, etc.  Specify: Lib i + o
Maryland 21215-0036	in 72 hours 1 *natural',	pleted by	15. Decedent's Education (Specify only highest grade completed)	Decedent's Usual Occupation Give kind of work done during most of worki life. DO NOT use retired)	ing 16b.	Sind of Business/Industry
1212	led with lygiene. her than	Com	Se College (1-4or 5+)	amstress	Ga	rment Industry
/lanc	uld be fi Mental H arkad ot atic ever	To Be	17. Father's Name (First, Middle, Last) Salvatore Licari		e (First, Middle, Maid le Catalan	
Man	nd 2 shoulth and 27 is ma	- 3	19a. Informant's Name/Relationship (Type, Print) (Daughter) 9b. Mariann Pedrotti Krueger	Mailing Address (Street and Number or Rura $3356$ Brantley Rd. Gl		
Baltimore,	Pages 1 ar		20a. Method of Disposition  143 Burial 2 Cremation 3 Removal from State  20b. Place of cemetery	Disposition (Name of c, crematory or other place)	Date 20c.	Location - City or Town, State
Balti	permit. Departn Importe any inju		21. Signature of Funeral Service License	<sup>22</sup> Name and Address of Facility Castle Hill Funer 1528 Castle Ave.	Bronx, NY	ors, Inc. 10462
8760,	cale be executed /Medical Examiner ithe burial-transit	dicai Examiner	23a. Pa 1. Inter the disease, or complications that caused the death. Do not suck, in heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause in a consequence of the death. Do not suck that caused the death	Dementia (): ():	or respiratory arrest,	Approximate Interval Batween Onset and Death Years
P.O. Box 68	Physician: The law requires that the death certifical this certificate has been signed by the attending phyral director, page 2 should be detached for use as the	Completed by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
Ś	w requires that been signed b should be deta	ed by Pr	Part II. Other significant conditions contributing to death but not resulting in Essential Hypertension	the underlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death? 2 ☑No 3 ☐ Probably 4 ☐Unknown
al Reco	ysician: The law re is certificate has bee director, page 2 sho	Complet			24a. Was an autopsy performed?	
ſ Vitt	ysician: Th	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ EP/Outp		n (Check only one) me 5 ☐ Residence	6 ☐Other (Specify)
Division of Vital Record	Attending death. ctor: After	Certification;	2 Accident investigation 3 Suicide 6 Could not be 28e Place of Injury - At home, far	me of 28c. Injury at Work?  M 1 □ Yes 2 □ No	28d. Describe how in 28f. Location (Street	njury occurred  and Number or Rural Route Number,
ă	spitel or A		4 Homicide determined building, etc. (Specify)  29a. Certifier 1 Certifying Physician: To the best of my knowledge,	death occurred at the time, date and place	City or Town, Sta	
	To the Hospitel or within 24 hours after the Funerel Dir. completely filled in	Medical	(Check only one)  2 Medicel Exeminer: On the basis of examination and and manner stated.  29b. Signature and title of certifier	or investigation, in my opinion, death occurred	ed at the time, date a	and place, and due to the cause(s)  Date signed (Month, Day, Year)
)	•		30. Name and address of person who completed cause of death (tem 23s) (1			ny 11, 2005
	10		30. Name and address of person who completed cause of death (Item 23a) (I Harry LI, MD 10780 Hickory I		MD 21044	
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature	Andel		

			State of Maryland / Department of Health and Men  1- For State Registrar Certificate of Death		jiene	1 / 6, 20 /
			Decedent's Name (First, Middle, Last)  2. 0	Date of Deat	th CUU	3. Time of Dealh
	Physicia		Margaret Stricker Porter	Month	Day Year	2:45 AM
	/Medic Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	io rocy	4c. County of Dea	th
	LAGIIIII		MARINER HEALTH - BELAIR BELAIR		HAR	FORD
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Nrs. 8. [	Date of Birth	Year)   Ci	thplace (State or Foreign puntry)
	Director			ctober	25 1919   Balt	inore, Maryland
	and *		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	ith the Marylan or 28a-f show	0	Maryland Harford Bel Air			1 ☐ Yes 2 ☐ No
	the ?	rect	10e. Street and Number 10f. Zip Code	1	l0g. Citizen of What Co	ountry?
	3a or	Ī	14 Linwood Court 21014		USA	
	death	Funeral Director	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rica	Yes or No-		
စ္	after or Ite	Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes Give 1 ☐ Yes 2 ☐ No Specify:	11, 610.7		
93	ural',	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:		VVL	rite
21215-0036	within 72 hours after death with the Maryland ene. then "netural", or items 23a or 28a-f show tro Madical Examirier must be notified at	Be Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired)		16b. Kind of Business	/Industry
12	withir ane. then	mo	Elementary/Secondary (0-12) College (1-4or 5+)  12 V/A Homemaker		Housekeeping-	-Own Home
g 7	filed Hygi other	CC	17. Father's Name (First, Middle, Last)  18. Mother's Name (Fir			OHLI IZZIZ
<u>a</u>	itd be lental ked c	To B	Phillip Stricker Anna Margane	et Lou	rise Schaefer	2
Maryland	shou and M e mar umet	_	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Ro	ute Number	r, City or Town, State,	Zip Code)
	and 2 alth a 127 io		Jill S. Trupia 29 Lyndale Avenue Baltimore, N	-		
ore	of He of He fiten		20a. Method of Disposition  20b. Place of Disposition (Name of cemetary, crematory or other place)  20b. Place of Disposition (Name of cemetary, crematory or other place)		20c. Location - City or	Town, State
Ĕ	Pag ment ent: I ury o		4 Donation 5 Other (Specify) Gardens of Faith Cem. May 13 2005		Baltimore, M	aryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other then "netural", or Items 23a or 28a-1 show any injury or other treumetic event. It was used Examinating the notified at once.		21. So at re of Funeral Service Licensee  22. Name and Address of Facility  Lassann Funeral Home Inc			
	00540		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or res	Mi. 21	236	Approximate
			shock, or heart failure. List only one cause on each line.	spiratory arr	631,	Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. Congriture heart			Jyeurs
	Examiner		Due to (or as a consequence of):	Oin		3 VIIII
		er	Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):			114.5
1 10	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c			
10	te be executed ysician and te burial-transit	Ex	resulting in death) Last Due to (or as a consequence of):			
376 376		Ilcal	d			
	n certifica anding ph use as tl	Mec	IF FEMALE:			
4 8 8	that the death certifica ed by the attending ph detached for use as t	Physician/Med	23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy  1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  4 ☐ Pregnant at time of death 5 ☐ Other (specify)		23d. Date of de Month	livery Day Year
0.1	he de the s	ysic	1 Tyes 2 Tho 9 Unknown 9 Unknown			
~ a	es that the de gned by the be detached	/Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	bacco use contribute t	o the cause of death?
A As	uires 1 sign 1d be	d by		1 🗆 Y	es 2 No 3 □ P	robably 4 Unknown
N ecor	The law requires ite has been sign age 2 should be	Completed		24a. Was a	an 24b. Were a	utopsy findings available
Re	The lavate has	omp		autops perfori	med? death?	completion of cause of
ta	en: tiffica tor, p	a	25. Was case referred to medical 26. Place of Death (Cl			
Q >	S S 5	ToB	examiner? 1   Yes 25 No	5 🗆 Reside	ence 6 □Other (Spe	ocify)
11)			27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Manural 5 Pending (Month, Day Year) 28b. Time of Injury 28d.	Describe he	ow injury occurred	
1/C	eath or:	catio	2 Accident investigation M 1 Yes 2 No			
€ \\ \bar{\bar{\bar{\bar{\bar{\bar{\bar{	after d Direct	Certification:	Zee. Place of Injury Actionie, family Street, factory, office	City or Town	treet and Number or R n, State)	urai Houte Number,
0	pite ours orel		29a. Certifier TS Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and	due to the c	rause(s) and manner a	s stated
3	a Hospitel 24 hours a Funerel I	edical	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a and manner stated.	it the time, d	date and place, and du	e to the cause(s)
	To the Hos within 24 ho To the Fun completely (	Me	29b. Signature and title of certifier 29c. License number	2	29d. Date signed (Mon	th, Day, Year)
	. > - 0		D37652	1	May 11;	2005
	Oi		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		A A BH	
_	\	,	2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a and manner stated.  29b. Signature and title of certifier  29c. License number  D 3 +6 5 - 2  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  S C O + Ha Will 2 Movile Avenue B1/A1x Muvil  31. Date filed (Month, Day, Year)  WAY I 3 2005	y land	21019	
	. C+	ite	31. Date filed (Month, Day, Year) 32. A Signature MAY 1 3 2005			

			State of Maryland / Department of Health and N	nental Hyg	giene	
			1- State of Maryland / Department of Health and No. 15 State Amend Item 24a per Verb., G843-05/13/05/13/05/15/15			16257
	Physic	cian	1. Decedent's Name (First, Middle, Last)	2. Date of Dea Month	Day Year	3. Time of Death
	/Med	ical	Isabelle Paulantonio  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death		6, 2005 4c. County of Dea	11:50A M
	Exam	iner	Oak Crest Care Center Parkville		Ba1	timore
	Funera		5, Social Security Number  6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birt (Month, Day	y, Year) C	rthplace (State or Foreign country)
	Directo	r	092-05-7452 1 1 M 2 M P 91 Yrs. Usual Residence of Decedent	July 15	5,1913   Bro	ooklyn, NY
	yland		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	e Man	ctor	MD Baltimore Parkville			1 ☐ Yes 2 X No
3	vith th	Funeral Director	10e. Street and Number 10f. Zip Code		10g. Citizen of What C	country?
8	eath v	erai	8800 Walther Blvd.  21234  11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Sp. 14 Mexican, Puerto	pecify Yes or No-	USA - 14. Race - Am	erican Indian,
=======================================	or Itan	F	1 N Never Married 2 ☐ Married 1 ☐ Yes 2 N No	Rican, etc.)	_	
	-0036 hours after death with the Maryland turel; or Itams 23s or 28s-f show at Exeminer must be notified at	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:		Specify: Wh	
25	15-(	Completed	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	king	16b. Kind of Business	s/Industry
\$	vithii iene.	dmo	Elementary/Secondary (0-12)   College (1-4or 5+)   Secretary   Secretary		Edicate	School
2	nd 2	BeC		e (First, Middle,	Maiden Sumame)	
Ja.	yla:	10		lella Po		Zi- Code)
a.	Maryland 21215-0036 d 2 should be filed within 72 hours af th and Mental Hygiene. th served other than "naturel; or treumatic event, ILE Medical Exam		John Poggi/Nephew  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rull)  1914 Billy Barton Cir			
0)	re, land Healt Healt tem 2		20b. Place of Disposition 20b. Place of Disposition (Name of	Date	20c. Location - City o	
K	Pages lent of nrt: If I		1 □ Burial 2 □ Cremation 3 ☑ Removal from State 1 □ Donation 5 □ Other (Specify)  1 □ Burial 5 □ Other (Specify)  May 20	005	Brooklyn	, NY
solvele faulantonia Irscam	Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "naturet; or Itams 23s or 28s-1 show any injury or other treumatic event, Ite Medical Examination matters.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lemmon Funeral Home	of Dul	aney Valle	y, Inc.
73	4024		Michael J. Flagle 10 W. Padonia Road  23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac	Timonium or respiratory ar	m, MD 2109 rest,	Approximate
	Physician		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final			Interval Between Onset and Death
	/Medica	ı	disease or condition resulting in death)  Due to (or as a consequence of the condition of t			
	Examine		Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):			
	ted	Examiner	Cause, Enter Underlying Cause (Disease or injury			
	'60, be executed sician and burial-transit	Exar	that initiated events c.  resulting in death) Last Due to (or as a consequence of):			
	# % B	Icai	d			
	Records, P.O. Box 68 The law requires that the death certifica tte has been signed by the attending ph age 2 should be detached for use as th	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of de	nivon.
1	Box eath cert attendin	cian	23b. Was decedent pregnant  1  Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?		Month Month	Day Year
	P.O.	hysi	1   Yes 2 No 9   Unknown			
	ds, Faures that signed I	by	Part II, Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.		obacco use contribute t res 2□No 3□F	to the cause of death?
	cords, wrequires been sign should be	eted	- Ins Maje almaisa			
~	of Vital Records,  Physicien: The law requires t  ribis certificate has been signe rral director, page 2 should be e	Completed		24a. Was autop perfo	rmed? death?	utopsy findings available completion of cause of
3	tal   en: Th tifficate or, pa	a	25. Was case referred to medical 26. Place of Dea		7x	s 2 No
+	of Vital Re( Physicien: The tave this certificate has ral director, page 2	To B	examiner? 1   Yes 2   No		dence 6 □Other (Spe	ecify)
9	T gr		27. Manner of Death  1 Natural 5 Pending (Month, Day Year) 28b. Time of Injury 28c. Injury 28c. Injury 3 Work?  1 Natural 5 Natural 5 Natural 1 Na	28d. Describe h	now injury occurred	
36	Division  lor Attending after death. Director: Atte	licat	2 Accident all vestigation 3 Suicide 6 Could not be 388 Blace of Injury. At home, farm, street, factory, office		Street and Number or F	Rural Route Number,
	Div Blor A safter I Dire	Certification:	4 Homicide determined building, etc. (Specify)	City or Tox	m, State)	
	Division of  To the Hospitel or Attending Ph within 24 hours after death.  To the Funeral Director: Atter th completely filled in by the funeral	edical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.			
	To the within 2 To the complete	Me	29b. Signature and title of certifier 29c. License number		29d. Date signed (Mor.	nth, Day, Year)
			1 as to will buy Brigh	2	5/6/05	
(	(1)		30. frampand address of person who completed cause of death (Item 23a) (Type, Print) [and	Curlle	ind 2	1234
	S Regis	tate strar	31. Date filed (Month, Day, Year)  MAY 1 3 2005  32. Registrar's Signature			

05-03217 Charles Parks RJD

# 

			1- State of Maryland / Department of Health and Mental Hygiene Certificate of Death  Reg. No. 2 0 1 5 1 6 2 5 3
	Physic		1. Decedent's Name (First, Middle, Last)  CHARLES W. PARKS  2. Date of Death Month Day Year  3. Time of Death
	/Medi Exami		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death
			Johns Hopkins Hospital Baltimore NA
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 25 Yrs.  1 M N 2 F 7. Age (In yrs. last birthday) 1 M N 2 F 1 Months 1 Mont
	iand ow		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
	with the Maryland a or 28e-f show Le notified at	tor	MARYLAND NA BALTIMORE 15 Yes 2 No
	or 28	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
	death w	rall	630 SCOTT STREET 21230 USA
21215-0036	or ite	by Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1
5-0	72 hours "naturel", dicul Ex-	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) 16b. Kind of Business/Industry
121	if " E N	ldmo	Elementary/Secondary (0-12) College (1-4or 5+)
d 2	Hygid Othar ent, I	Be Cc	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Sumame)
/lan	2 should be filed within and Mental Hygiene. is markad othar than aumatic avent, h. M.	To B	CHARLES W. PARKS RITA BATTLE
, Maryland	ges 1 and 2 should be filled wil ti of Health and Mental Hygiend If item 27 is markad othar thu or other traumatic avent, the		19a. Informant's Name/Relationship (Type, Print)  RITA BATTLE MOTHER  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  630 SCOTT STREET BALTIMORE, MARYLAND 21230
Baltimore,	of He of He If Item or oth		20a. Method of Disposition  1 Date  20c. Location - City or Town, State  20b. Place of Disposition (Name of cemetery, crematory or other place)
tim	tment tant: tant:		'4 Donation 5 Other (Specify) MT. ZION CEMETERY MAY 14, 2005 LANSDOWNE, MARYLAND
Ba	permit. Pages 1 and 2 Department of Health s Important: If Item 27 is any injury or other tra gnce.		21. Signature of Funeral Service Licensee  22. Name and Address of Facility WYLIE FUNERAL HOME P.A.
			23a. Part 1. Enter the disease, or simplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Let only one caus on each line.  Approximate Interval Between
	Pnysician	, J	Immediate Cause (Final Onset and Death
	/Medical		disease or condition resulting in death)  a.   Oue to (or as a consequence of):
	Examiner		Sequentially list conditions, b
J	nsit	Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury  Due to (or as a consequence of):
,	executed in and ial-transit	Exar	that initiated events c. Pue to (or as a consequence of):
68760,	icate be executed physician and s the burial-transit	dical	d
_	ertifica ling ph e as th	0	IF FEMALE:
Вох	death certific e attending p od for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 3 Ectopic pregnancy
o.	0 0	nysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown 9 ☐ Unknown 9 ☐ Unknown
Δ.	iaw requires that the as been signed by th 2 should be detache	by Pł	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?
ords	w require been sig should b	ted t	1 Yes 2 You 3 Probably 4 Unknown
Records,	has be ge 2 sh	Completed	24a. Was an autopsy prior to completion of cause of
	Th ate pag	Con	performed? death?  10 Yes 2 No 14 Yes 2 No
Vital	ding Physician: Th. n. After this certificate funeral director, pag	Be c	25. Was case referred to medical examiner?  1X Yes 2 No  Other: 4 Nursing Home, 5 Residence 5 Residenc
of		n: To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred
ion	ttanding fideath.	atlo	1 Natural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation 5 S TO No Subject School
Division	or Attanding ifter death. Diractor: After in by the fune	Certification:	3 Suicide 6 Could not be determined 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
	pital o		Theet Gooding Scott Street
	A Hos	Medical	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
	To the Hospitel or Attene within 24 hours after death To the Funerel Director: completely filled in by the	Me	29b. Siggature and title of pertifier 29c. License number 29d. Date signed (Month, Day, Year)
•			May 10, 2005
	4		30 Name and address of person who completed cause of death (Item 23a) (Type, Print)  111 Penn Street Baltimore, Maryland 21201
	Sta	e	31. Date filed (Month, Day, Year) 32. Registrar's Signature
	Registr		MAY 1 3 2005 Bear & Could
DHN	/H 17 Rev 1/20	01	HOURS IT GOOD
			ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 🛭 🗍 5 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Rose Poulin Month 1:40 AM May 11 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Mariner Health of North Arundel Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Jan. 31, 1914 5. Social Security Number Funeral 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 2 🕅 F Director 006-03-2986 91 Yrs Canada Usual Residence of Decedent death with the Maryland 10a State 10h Counts 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Exertiner must be notilized at 10d. Inside City Limits Director MD Anne Arundel 1 ☐ Yes 2 X No Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 629 West Phalia Court Funeral 21061 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White ρ 3 Widowed 4 □ Divorced Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hyglene. Important: If item 27 is marked other than "reany injury or other traumatic event in any injury or other traumatic event. College (1-4or 5+) Elementary/Secondary (0-12) Factory Worker Shoes 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jules Audet Celanire LaBonte 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Remolde Granddaughter 6545 Carlinda Avenue, Columbia, MD 21045 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 Cremation 3 Removal from State 4 □ Denation 5 □ Other (Specify) St. Peter's Cemetery 5-16-2005 Lewiston, Maine Signatur of F neral Service Licensee Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) year /Medical to (or as/a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4 Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 A N 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Vursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation M after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 - Homicide filled 24 hours a 1 Dentifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier ompletely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I 29b. Signature any 29c. License number 29d. Date signed (Month, Day, Year) person who completed cause of death (Item 23a) (Tyge, Print) 11107 Madisar rhety and 32. Registrar's Spnature State

Registrar

2 2005

			1- For State of Maryland / Department Certification	ent of Health and Me ate of Death		ene 3.No. 005 16260
	Physic /Medi Examir	cal	1. Decedent's Name (First, Middle, Last)  NRTLE M REID  4a. Facility Name (If not institution, give street and number)  4b. Ci		2. Date of Death Month	Day Year 3. Time of Death  1:30 P M  4c, County of Death
	Funeral	iei	NORTHARUNDEL HOSP 1774L  5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)  Month	LEN BURNE  der 1 Year   If Under 24 Hrs.   hs Days Hours Min.	8. Date of Birth (Month, Day, Y	ANNEARUNDEL  9. Birthplace (State or Foreign Country)
	Director		228-28-0163         1		Oct 17,	1928   North Carolina
	death with the Maryland ms 23a or 28a-f show rmust be calified at	Director	MD Anne Arundel Millersville  10e. Street and Number 10f. 2	Zip Code	100	1 ☐ Yes 2 🗖 No g. Citizen of What Country?
M 036	<u> </u>	by Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married 1 1 Yes, si	21108 seedent of Hispanic Origin? (Spec specify Cuban, Mexican, Puerto R s 2 X No Specify:		U.S.A.  14. Race - American Indian, Black, White, etc.  Specify: White
$E_{ID}$ , MyR7LE $M$ limore, Maryland 21215-0036	2 should be filed within 72 hours after and Mental Hygiene. Is merked other than "natural", or Ite raumstic event, the Medical Examination.	Completed	Elementary/Secondary (0-12) College (1-4or 5+) Secretar	work done during most of working Tuse retired)	g	Sb. Kind of Business/Industry United States Government
1/K	uld be fi dental H rked ot tic ever	To Be	17. Father's Name (First, Middle, Last)  Alex Garland Adcock	18. Mother's Name (Blanche		rris
Mary	d 2 sho th and h 7 Is ma trauma			ess (Street and Number or Rural		
REID, altimore, 1	Pages 1 and nent of Healt ant: If Item 2 ury or other		20a. Method of Disposition 1 ☐ Burial 2 蚤 Cremation 3 ☐ Removal from State	Name of Da	ite 20	Maryland 21032  c. Location - City or Town, State  denton, Maryland
Balti	permit. Departn Imports any inje		M00//3 1411		ome & Cro Odenton,	ematory, P.A. Maryland 21113
	Fnysician /Medical		23a. Part1. Enter the disease of complications that caused the death. Do not enter the m shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):		respiratory arrest	t, Approximate Interval Between Onset and Death
8760,	icate be executed by physician and burial-transit sthe burial-transit	dlcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  c. UCS,7,1,1+0,12 4  Due to (or as a consequence of):  d.	Himto	Filom	CONGERNION
P.O. Box 6	ath certif attending for use as	Physician/Me	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 4 Pregnant at time of death 5 Other (			23d. Date of delivery Month Day Year
	w requires that the deben signed by the should be detached	by	Part II. Other significant conditions contributing to death but not resulting in the underlying	g cause given in Part I.		cco use contribute to the cause of death? 2 ☐ No 3 ☐ Probably 4 ☑ Ūnknown
al Reco	elcian: The law re certificate has be irector, page 2 shr	Completed			24a. Was an autopsy performe 1 Yes 2	
r Vit	yelciar is certif director	To Be	25. Was case referred to medical examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 I	26. Place of Death ( DOA Other: 4 Nursing Home		ce 6
Division of Vital Records,	To the Hospital or Attending Phyelcian: The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification:	27. Manner of Death  1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation  28a. Date of Injury (Month, Day Year)  28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	ld. Describe how	
Div	lospital or A hours after uneral Dire		3 ☐ Suicide 4 ☐ Homicide  28e. Place of Injury - At home, farm, street, factor building, etc. (Specify)  29a. Certifier (Check only)  1 ☐ Certifying Physician: To the best of my knowledge, death occurre (Check only)  2 ☐ Medical Examiner: On the basis of examination and/or investigation.	ed at the time, date and place, an	City or Town, S	Sa(s) and manner as stated
	o the H ithin 24 o the F omplete	Medical	and manner stated.	29c. License number		. Date signed (Month, Day, Year)
	pm ≤ pm ()		· Bechu	10053-703	2 - 2 - 2 - 2 - 2 - 2 - 2 - 2 - 2 - 2 -	5/6/05
	4		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  73.00 BLUHAND NORM ALUNDER 1	HOSPIDAL GLER	BURNI	~ mb 21061
	Sta Registr	4	31. Date filed (Month, Day, Year)  MAY 1 3 2005  32. Registrar's Signature			

State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** MARBALET RILDISILI 2005 /Medical 4c. County of Death 4e. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Maspita more city Age (In yrs. last birthday)
Yrs. Social Security Number Birthplace (State or Foreign
 Country) **Funeral** 1 ☐ M 2 💢 F Director lary Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show f Health and Mental Hygiene. Item 27 Is marked other than "nature!", or Itema 23a or 28a-1 shov other traumatic event, the Medical Examinar must be notified at 1 ☑ Yes 2 ☐ No Director MORR 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2120 3901 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 25 No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: Black 3 ☐ Widowed 4 S Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surfame) 17. Father's Name (First, Middle, Last) Be 9 Mar 2 Pages 1 and 2 should 19a. Informant's ame/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) 3901 naon, 110 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, Stete cemetery, cremator 1 Burial 2 ☐ Cremation 3 Removal from State 6 permit. Page Department of Important: If any injury or once. \* 4 ☐ Donation 5 ☐ Other (Specify) 14 a 2005 21. Signature of Funeral Service License 23. Name and Address of Facility ce 45 30/20 Cullon 23a. Part 1. Enter the disease, or complications that of used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on contains. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Panereatitis **Physician** /Medical Examiner PITHELIAL CANCER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. ed by the a 9 Unknown 9 Unknown been signed the should be detailed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate 2 No Division of Vital 1 ☐ Yes 2 7 No 1 ☐ Yes director 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 🗌 Yes 2 🖳 🗸 🗸 0 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 1 ⊠Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Injury 5 Pending death. 1 ☐ Yes 2 ☐ No nours after death.

neral Director: A filled in by the fe 2 Accident investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Hospital or within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 Molugeta Fisha , NOB 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MULUGETA OHNS HOPKINS HOSPITAL GOON-WOLFEST, BALTIMONS, MA 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 1 3 2005 Registrar

Year

Hospitel or Attending Physicien: hours after death. Director: 24 hours a within 2

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 (S) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature/ahd 29c. License number 29d. Date signed (Month, Day, Year) OCME May 10, 2005 30. Name and address of person who combleted cause of death (Item 23a) (Type, Print) 111 Penn Street Baltimore, Maryland 21201 1+0GA1 32. Posistrar's Signature 31. Date filed (Month, Day, Year) MAY 13 2005

Bridge

Registrar

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State of Maryland / Department of Health and Mental Hygiene) = For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Dorothy Hayghe Smith 9, May 2005 11:45 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Talbot 12390 Blades Road Cordova If Under 1 Year Months Days 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) AUG. 15, 1 Birthplace (State or Foreign Country) **Funeral** Months Hours Min. 235-32-2131 1 ☐ M 2 🖾 F 88 Director 1916 Washington, DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location or 28a-f show 10d. Inside City Limits the Medical Examiner must be notified at Director MD Talbot 1 Yes 2X No Cordova 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Иетв 23£ 12390 Blades Road 21625 USA filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2X No Specify: þ Specify: white 3 Widowed 4 □ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry than permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12 Receptionist Banking 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) Virginia Lewis William E. Hayqhe 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Dorothy A. Smith - daughter 12390 Blades Road, Cordova, MD 21625 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 Cremation 3 ☐ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Wash. Crm. Laurel, MD 5/11/2005 21. Signature of Funeral Privile Urensee 22. Name and Address of Facility
Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc. any ir 7250 Washington Blvd., Elkridge, MD 21075 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. 23a, Part 1. Enter the disease Approximate Interval Between Onset and Death shock, or heart failure List only Immediate Cause (Final disease or condition resulting in death) Pny≲ician /Medical Due to (or as a consequence of) Examiner (errited CANCE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): physician a s the burial-t P.O. Box 68760 as IF FEMALE esu. 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 DEctopic pregnancy in the past 12 months? for Month Day Year 5 Other (specify) the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 □Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed page certificate 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 🗌 Yes 2 No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) P 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Diractor: A investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ 4 Homicide filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) 141339 30. Na e and iddress of person who completed cause of death (Item 23a) (Type, Print) 130 STEVENSLILLE Harms mo N JAMIE LOVE POINT mo 2,666 Registrar's Signature 31. Date filed (Month, Day, Year) State MAY 1 3 2005 Registrar

			1 - For State Registrar	State of Marylan			t of Healt e of Dea			giene Reg. No.	005	16264
			Decedent's Name (First, Middle, Last)						2. Date of Dea		.,	3. Time of Death
	Physici /Medio		Ronald	Saunder	s				April 2	24, Day 20	005 Year	9:55 AMM
	Examir		4a. Facility Name (If not institution, give st	reet and number)		4b. City,	Town, or Locat	tion of Death	<u> </u>	4c. Cc	ounty of Death	<del></del>
			Prince George's G	eneral Hospi	tal	Che	verly			Prin	nce Geo	orge's
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.		If Under Months		nder 24 Hrs. urs Min.	8. Date of Birth Month, Day Aug • 1	h VoYear)	9. Birth	place (State or Foreign
200	Director		711 02 01/0	M 2□F 55	Yrs.				Aug. 1	0, 19	49 New	Jersey
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Lo	cation						10d. Inside City Limits
	Aaryli sho	ក	MD Prince Ge		Landove							1 ☐ Yes 2 X No
	28a-1	Director	10e. Street and Number	orge 3	dandove	10f. Zip	Code			10a Citize	n of What Cou	unto/2
	with with the party of the part		8702 Post Oak Way				785			USA		
	filed within 72 hours after death with the Maryland Hygiene. Ither than "natural", or Items 23e or 28e-f show ent, Itte Macked Examiner must be natified at	Funeral		2. Was Decedent Ever in U	.S.   13. \			c Origin? (Spe	ecify Yes or No-		Race - Amer	ican Indian,
20	or iter	Έ	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No	'	f Yes, spec	offy Cuban, Mea	xican, Puerto	Rican, etc.)		Black, White	, etc.
<u>ල</u>	al', o	by	3 ☐ Widowed 4 🕅 Divorced	If Yes, Give Year or Dates:		1□Yes :	2X No Spe	ecify:		Sp	ecify: B	lack
2	72 ho	Completed	15. Decedent's Educa (Specify only highest grade		16a. Deced	dent's Usua	al Occupation	most of work	ina	16b. Kind	of Business/le	ndustry
2	ithin	npie	Elementary/Secondary (0-12)	College (1-4or 5+)			rk done during se retired)		9		. •	
21	ygier ygier nerth			4	Scho	ool To	eacher				cation	
<u> </u>	be fil Ital H Id off	Be	17. Father's Name (First, Middle, Last)						e (First, Middle,		mame)	
3	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other than "natural", or items 23e or 28e-f show aumatic event, it is Modical Examiner must be notified at	10	Richard Earl Saund						e Coley			
100			19a. Informant's Name/Relationship (Type Marilyn Hill – Sis						a/Route Numbe e Bowie		0wn, State, 21 20721	p Code)
	1 an Heal em 2 ther		20a. Mathod of Disposition	20b. F	lace of Dispo	sition (Nan	ne of	-	Date		tion - City or T	own State
Baltimore,			1 Burial 2 ☐ Cremation 3 ☐ Re	moval from State	emetery, cren	natory or o	ther place) Church	1				County, TN
	permit. Page Department Important: Important: I any injury o		* 4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee							Monteg	Omery	Country, IN
Ba	Depa Impo any i		MILINIST	00000	)   "		d Address of F ker Fun			1 .	11	270/0
老			23a Part   Enter the disease, or complication	ations that caused the deat	n. Do not ente				eet Cla		11e, T	
49		V	shock, or heart failure. List only one Immediate Cause (Final	cause on each line.			, ,					Approximate Interval Between Onset and Death
	nysician /Medical		disease or condition resulting in death)	CIRDIO Due to (or as a conseq	ORL-SI	IRA	FORY	17K	REST			
	Examiner			PNICU		٨						
ş		-E	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Due to (or as a conseq		7						
V	outed d ansit	Examiner	Cause (Disease or injury that initiated events									
o O	be executed ician and burial-transit	EX	resulting in death) Last	Due to (or as a conseq	uence of):							
8760	icate be executed physician and s the burial-transit	dlcai	d.									
9	The law requires that the death certificate te has been signed by the attending physoge 2 should be detached for use as the I	Med	IF FEMALE:								1	
gox	eath certific attending p	an/	23b. Was decedent pregnant in the past 12 months?	<ol> <li>If yes, outcome of pregnant</li> <li>1 ☐ Live birth 2 ☐ Feta</li> </ol>	death 3	Ectopic pr	egnancy			23d	. Date of deliv Month	ery Day Year
0	at the dea by the al	sici	1 Yes 2 No	4 Pregnant at time of d 9 Unknown	eath 5□	Other (sp.	ecify)				MOIIII	Day fear
٠.	that the	Physician/Me	Part II. Other significant conditions conta	abuting to death but got rec	ulting in the us	dorh ing o	nuon anyon in D	last I	23a Did to	haaaa usa	contributo la l	he cause of death?
က်	signe bed be	l by	- ^	AILURE	asting in the di	idenying G	ause given ni r	diti.		es 2 $\square$ N		bably 4 Didniknown
0	w requir been si should I	etec	, , , , , , , , , , , , , , , , , , , ,									
ě	has has be 2 s	Completed	HYPERT	ENSION					24a. Was a autop: perfor	sy	4b. Were auto prior to co death?	opsy findings available empletion of cause of
	10 L								1□ Yes		1 Yes	2□ No
Vital Records,		o Be	25. Was case referred to medical examiner?	spital:			Other		(Check only or			
	Phys rthis raldii	-	1 ☐ Yes 2 ☑ 4No  27. Manner of Death	1 Limpatient 2	ER/Outpatien 28b. Time of	_	A   4L		me 5 Resid			( <del>y</del> )
6	tending F death. tor: After the funera	tho	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	м	8c. Injury at Work? 1 ☐ Yes			o 11 11 July 0		
Division of	r Attending er death. rector: After by the fune	fica	3 Suicide 6 Could not be	28e. Place of Injury - At he	ome, farm, stre	eet, factory	, office		28f. Location (S	treet and N	umber or Run	al Route Number,
É	E Sitt	Certification;	4  Homicide	building, etc. (Specific	1)				City or Tow	n, State)		
	Hospital 24 hours a Funeral [ tely filled		29a. Certifier La Certifying Physic	cian: To the best of my kno	wledge, death	occurrad a	at the time, dat	e and place, a	and due to the c	ause(s) and	d manner as s	stated.
	To the Hos within 24 h To the Fur completely	Medical	(Check only 2 Medical Examine one)	r: On the basis of examina and manner stated.	tion and/or inv	estigation,	in my opinion,	death occurr	ed at the time, d	date and pla	ice, and due t	o the cause(s)
	To the Hospital within 24 hours a To the Funeral Completely filled	Σ	29b. Signature and title of certifier			290	. License numb	_	2	4 4	gned (Month,	
			· Tune	un Cer	MD	D	0058	5290		4/0	24/05	
	2		30. Name and address of person who com									
	)			UTTATH 40	203 0	OGE	NSBUR	RY RI	D. HYA	575V	ILLE	M5 20781
	Sta Registr		31. Date filed (Month, Day, Year)	2005 Registrates Signa	ture //	100	and I					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 6.59A *-ugene* ummers 2005 /Medical la, 4a. Fecility Name (If not institution, give street and number) County of Death Examiner 4b, City, Town, or Location of Death Forest Haven Nursing Home If Under 1 Year | If Under 24 His more Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country),
 i **Funeral** 100M 2□F Months Days Hours 12 218-28-274: Yrs. Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location r 28a-f show 10d. Inside City Limits 1 ☐ Yes 2 1 No Completed by Funeral Director HARFORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ir than "naturel", or items 23a or the Modical Examiner must be 21014 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No 3 Widowed 4 Divorced White. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. uder write INSURANCE 1a permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other eny injury or other traumatic event, I 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill thent of Health and Mental Hitant: If item 27 is marked oth Be 18. Mother's Name (First, Middle, Maiden Sumame) Dummers, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Highland Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5-13-05 FORESTHILL, MO EVANSFUNERAL CHARCL 21. Signature of Funeral Service Licensee 22. Name and Address of Facility RD., Timonium, MD 21093 23a. Part1. Enter the disease, or complications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lin. PEACEFULALTERNATIVES FUNERAL + CREMATION CENTER Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician UNTINCITONS /Medical deconsequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Be Completed by Physician/Medical Examiner Due to (or as a consequence of) sicien and burial-transit Due to (or as a consequence of): Box 68760. use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? as been signed by the atte 2 should be detached for Day Year 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 DUnknown 1 ☐ Yes 2 ☐ No 3 Probably 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? page 1 Yes 2 No Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification; To 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Division of 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28b. Time of 28c. Injury a! Work? 28d. Describe how injury occurred ₩ Natural 5 Pending death. 2 Accident investigation 1 Tes 2 No within 24 hours after deatl To the Funeral Director: completely filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 28595 12 lelian 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

MASNEEM

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

MAY 1 3 2005 June 15

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AKHANI,

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** SMITH /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death

BALTIMORE Examiner 4c. County of Death BALTIMORE REHABILITATION EXTENDED CARE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 1 M 2□F 216-30-7308 Usual Residence of Decedent **Director** 216-30-MARYL Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. and to 17 is marked othar than "natural", or Itams 23s or 28s-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic avant, the Medical Exercited must be notified at MD Director 1 Yes 2 No BALTIMORE TIMORE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 12. Was Debedent Ever in U.S. Amted Forces? 1 17 yes 2 No 21236 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗖 No þ Specify: White 3 Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Stanley 19a. Informant's Name Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a t: If itam 27 is 7 or other trau BALTIMOZE. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town. State Men. Kark 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Pensee 22. Name and Address of Facility MORE, MO 21234. EVAIDS FUNERAL CHAPFL SOONHARFARD RO 23a. Part1. Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician LIVFECTION days /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Be Completed by Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4□Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Minknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗆 No 2 **X** No 1 Yes 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 🗌 Yes Certification; To 1 Inpatient 2 ER/Outpatient 4 Valursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending M 1 ☐ Yes 2 ☐ No within 24 hours after death. To tha Funaral Diractor: A investigation 6 Could not be determined 3 🗍 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) an and address of person who completed cause of death (Item 23a) (Type, Print) Loch RAVEN BULLEVARD 31. Date filed (Month, Day, MAY 1 3 2005 32. Registrans Signature State Registrar

			1 - For State Registrar	State of M	aryland		artment tificate			ınd Me		giene Reg. No	711115	16	267
	Physic	ian	1. Decedent's Name (First, Middle, Last, Robert N. Smith	)							2. Date of Dea Month 05	Day			of Death
	/Medi Examir		4a. Facility Name (If not institution, give	street and number)				Town, or	Location of	f Death	05	07 4c.	2005 County of Dea	ath	:40a <sup>M</sup>
	Funeral Director		5. Social Security Number 6. Sec	7. Ag	ge (In yrs. las 84	st <i>birthday)</i> Yrs.	If Under Months		If Under 2 Hours	Min.	8. Date of Birt (Month, Day 08-19	y, Year)	9. Bi	rthplace (State country)	
	show		10a. State 10b. County		10c. City,	Town or Lo	cation							10d. Inside	City Limits
	the Ma	Director	MD Montgon	ery	Roc	kvill		Codo				10- 0"			s 2 No
	h with	E D	28 Chantilly Ct.				10f. Zip	Code	2085	.0		_	izen of What C	ountry?	
336	be filed within 72 hours after death with the Maryland tal Hygiene. ad other than "natural", or Items 23s or 28s-1 show event, the Medical Everting roust be routiled at	by Funeral		12. Was Decedent Armed Forces? 1—1 Yes 2 [] If Yes, Give Year or Dates:		1	Was Deced f Yes, spec				ify Yes or No- ican, etc.)		14. Race - Am Black, Whi	ite, etc.	
215-00	ithin 72 hound.	Completed	15. Decedent's Edu (Specify only highest grad	cation		16a. Deced (Give life. L	kind of wor DO NOT us	k done di e retired)	ırina most	of working	7	16b. K	ind of Business	s/Industry	
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ary	2 shoul and Mils mari	F	19a. Informant's Name/Relationship (Ty	pe, Print)		19b. Mailin	g Address	(Street a	Mar nd Number	r or Rural	<u>ne Smit</u> Route Numbe	r, City o	r Town, State,	Zip Code)	
Baltimore, M	ealth m 27		Victoria Smith (d 20a. Method of Disposition 1 Burial 2 Scremation 3 P		cen	ce of Dispos	sition (Nam	e of her place	)	Da			0850 cation - City or	r Town, State	
Itim	permit. Pages 1 Department of H Important: If Its any injury or ot once.		<ul> <li>4 □ Donation 5 □ Other (Specify)</li> <li>21. Signature of Funeral Service Cicens</li> </ul>	90	Che	sapeal	ke Cre				05	Ве	ltsvill	e, MD	
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	/Medical Examiner	_		)	ic Ob	struct	tive l	Pulmo	onary	Dise	ease			3 ye	ars
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	10,		30. Name address of person who co J. Reilly 3418 01a				,	MD	20832	2			5		
i	Sta <del>R</del> egistr		31. Date filed (Month, Pay, Year) 3 20		ar's Signatur		who								

			For State Registrar	State of Maryland		ment of Health an ficate of Death	d Mental H	ygiene Rag. No. 0	05 16268
			1. Decedent's Name (First, Middle, La	st)			2. Date of I	Death Day	3. Time of Death
	hysicia/ Medic/		Edward Franc	is Sheehan,	Jr.		May	6	2005 9:50 A M
	Examin		4a. Facility Name (If not institution, giv	e street and number)	4	b. City, Town, or Location of D		4c. Coun	ity of Death
			Holy Cross Hosp	ital		Silver Spri	ng	N	Montgomery
Fı	uneral		5. Social Security Number 6. S		N	f Under 1 Year If Under 24 Ionths Days Hours I	Hrs. 8. Date of E Min. (Month, I	Birth Day, Year)	Birthplace (State or Foreign Country)
Dii	rector		020-46-0314	X 47	Yrs.			18,1957	Massachusetts
and	<b>3</b> \$	ł	Usual Residence of Decedent  10a. State 10b. County	10c, City, 7	Town or Locat	ion			10d, Inside City Limits
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The A	28a-1	Director	10e. Street and Number	ery		Silver Spr	Ing	10a Citizon o	f What Country?
With	a or	늅				20910			ed States
eath	te 23	Funeral	1704 Noyes Lane	12. Was Decedent Ever in U.S.	13 Was		2 (Specify Ves or I		ace American Indian.
ter d	ther	5	1 Never Married 2 Married	Armed Forces?	If Y	s Decedent of Hispanic Origin es, specify Cuban, Mexican, P	uerto Rican, etc.)	BI	ack, White, etc.
US a	0,0	by	3 ☐ Widowed 4 ☐ Divorced	1 Tes 25 No If Yes, Give A Year or Dates:	1 🗆	Yes 2\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\		Spec	eity: White
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Ore, Maryland es 1 and 2 should be file of Health and Mental Hy	ls marked eumatic ev		19a. Informant's Name/Relationship (	Type, Print)		Address (Street and Number o			
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Baltimore, permit. Pages 1 a Department of Hea	If Ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☒	Removal from State	e of Disposition of the contract of the contra	on (Name of ory or other place)	Date	20c. Location	- City or Town, State
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salt srmit.	ny inj		21. Signature of Funeral Service Line	M0038Z	22. N Rat	ame and Address of Facility op Funeral and	Crematio	on Servi	ces
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			23a. Part1. Ent or the disease, or com shock, or heart failure. List only	plications that caused the death. I one cause on each line.	Do not enter t	he mode of dying, such as car	rdiac or respiratory	arrest,	Approximate Interval Between
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I RECORDS, P.O. BOX 60 The law requires that the death certific	is certificate has been signed by the attending p director, page 2 should be detached for use as	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consequent of Due to	y sath 3 Ec	topic pregnancy her (specify)  rlying cause given in Part I.  26. Place of  Other: 4 □ Nursir	24a. We aut per 1 To Yes	No litobacco use con list an opsy formed? 2 No list an opsy sidence 6 0 0	ntribute to the cause of death?  3 \( \text{Probably} \) 4 \( \text{Npnknown} \)  Were autopsy findings available prior to completion of cause of death?  1 \( \text{Yes} \) 2 \( \text{No} \)  ther (Specify)
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IN OT VITAL RECORDS, P.O. BOX 60 IN Physician: The law requires that the death certific	To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	edical Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consequent of Due to	y sath 3 Ec th 5 Oi ng in the under VOutpatient Bb. Time of Injury e, farm, street, edge, death oc n and/or invest	topic pregnancy her (specify)  rlying cause given in Part I.  26. Place of 32 DOA Other: 4 Nursin Work?  M 1 Yes 2 No factory, office  coursed at the time, date and p igation, in my opinion, death of D0019924	24a. We per per per per per per per per per pe	I tobacco use coll  Yes 2 No  Is an opsy formed?  Young  Sidence 6 One  how injury occur  (Street and Numown, State)  e cause(s) and no  do date and place	ntribute to the cause of death?  3 Probably 4 Mnknown  Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No  ther (Specify)  ured  her or Rural Route Number,
II OI VITAI RECOTOS, P.O. BOX to the Physician: The law requires that the death certific	ifer this certificate has been signed by the attending p ineral director, page 2 should be detached for use as	edical Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consequent of d.  23c. If yes, outcome of pregnancy 1	y and a second control of the second control	topic pregnancy her (specify)  26. Place of Other: 4 Nursin Work?  M 28c. Injury at Work?  M 1 Yes 2 No factory, office  Courred at the time, date and prigation, in my opinion, death of the property of the	24a. We aput per location of the control of the con	No litobacco use con light of the literature of	ntribute to the cause of death?  3 Probably 4 Monknown  Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No  ther (Specify)  urred  Therefore Rural Route Number,  manner as stated.  and due to the cause(s)  and (Month, Day, Year)
II OI VITAI RECOTOS, P.O. BOX to the Physician: The law requires that the death certific	To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Medical Certification; To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consequent of d.  23c. If yes, outcome of pregnancy 1	y sath 3 Ecth 5 Oil ong in the under	topic pregnancy her (specify)  26. Place of Other: 4 Nursin Work?  M 28c. Injury at Work?  M 1 Yes 2 No factory, office  Courred at the time, date and prigation, in my opinion, death of the property of the	24a. We aput per location of the control of the con	No litobacco use con light of the literature of	Intribute to the cause of death?  3 Probably 4 Nnknown  Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No  Ither (Specify)  Urred  Inter or Rural Route Number,  Inter as stated.  In and due to the cause(s)

			1- State of Maryland / Departs Registrar  Certifit	ment of Health and M ficate of Death	lental Hygie	0000	0
	Physici	an	1. Decedent's Name (First, Middle, Last)  Robert Waitman Stoddard		Date of Death     Month	Day Year 3. Time of Death	
	/Medic Examir			c. City, Town, or Location of Death Silver Spring		4c. County of Death  Montgomery	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Under 1 Year If Under 24 Hrs. lonths Days Hours Min.	8. Date of Birth (Month, Day, Ye 05-14-1	0 ,	ign L
	aryland	2	Usual Residence of Decedent  10a. State  10b. County  10c. City, Town or Locatic  MD  Montgomery  Silver Sp.			10d. Inside City Lim	its
	with the M a or 286-f be nutifity	Director	Direct bp	10f. Zip Code 20906		1 ☐ Yes 2551 Citizen of What Country? USA	
336	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "neturel", or items 23a or 28e-f show eumatic event, Irs Madical Examiner must be nuffied at	by Funeral	1 ☐ Never Married 2 ☆ Married   1 ☆ Yes 2 ☐ No	i Decedent of Hispanic Origin? (Spess, specify Cuban, Mexican, Puerto Yes XXNo Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
Maryland 21215-0036	filed within 72 hou Hygiene. Ither than "neture ant, Ire Medical	Completed	(Specify only highest grade completed) (Give kind life, DO N	's Usual Occupation d of work done during most of worki NOT use retired) rior Designer	ng 16t	o. Kind of Business/Industry  Residential Servi	e e
land 2	should be filed and Mental Hygi s marked other umatic event, I	To Be Co	17. Father's Name (First, Middle, Last)  Walter C. Schnopp	18. Mother's Name	(First, Middle, Maid C. Hite		-es
_	and 2 shore		19a. Informant's Name/Relationship (Type, Print)  Daniel Stoddard (son)  17608	ddress (Street and Number or Rura Prince David Dr	l Route Number, Ci	ty or Town, State, Zip Code) MD 20832	
altimore,	Pages 1 ment of H ent: If iter ury or oth		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  '4 Donation 5 Other (Specify)	ory or other place)		Location - City or Town, State	
Balt	permit. Departi		HULL XOUMENN MO382 93	ame and Address of Facility LPP Funeral & Cre 3 Gist Ave Silve	er Spring	MD 20910	
No.	Prrysician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	Cardion, such as cardiac o	r respiratory arrest,	Approximate Interval Between Onset and Death	
,	cate be executed  physician and ithe burial-transit	Examiner	Sequentially list conditions, if arry, leading to inimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of).	egws.tatren			
09/89	death certificate be executed e attending physician and id for use as the burial-transit	dlcal	d.				
O. Box	at the death certifi by the attending patached for use as	hysician/Me		opic pregnancy ner (specify)		23d. Date of delivery Month Day Year	
rds, P.	signed d be de	by P	Part II. Other significant conditions contributing to death but not resulting in the under	lying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death? 2 ☑ No 3 ☐ Probably 4 ☐ Unknow	'n
II Kecords	The law ate has b page 2 sl	Completed			24a. Was an autopsy performed		le I
VItal	Physicien: The L this certificate ha ral director, page 3	o Be	25. Was case referred to medical examiner?  1  Yes 2 No  Hospital: 1   Inpatient 2   ER/Outpatient 3	26. Place of Death		6 □Other (Specify)	
ion or	ling After fune	atlon: T	27. Manner of Death  1 Statural 5 Pending (Month, Day Year)  28a. Date of Injury (Month, Day Year)	28c. Injury at Work?	8d. Describe how in		
DIVISION	e Hospitel or Attenc 24 hours after dealt e Funeral Director: etely filled in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, f building, etc. (Specify)	factory, office	8f. Location (Street City or Town, St	and Number or Rural Route Number, ate)	
	To the Hospitel or within 24 hours after To the Funeral Dir completely filled in	edical	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occ 2 Medical Examiner: On the basis of examination and/or investigated and manner stated.	urred at the time, date and place, a gation, in my opinion, death occurre	nd due to the cause od at the time, date a	e(s) and manner as stated. and place, and due to the cause(s)	
	To the within 2 To the I complet	Me	29b. Signature and title of certifier	29c. License number D 42777	29d. I	Date signed (Month, Day, Year) 05-10-2005	
	3+1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print, Richard Weinstein 1811 Prince	Philip Dow #	210 0/2	e1,MD Z0832	
	Sta Registr		31. Date filed (Month, Day, Year) 1 3 200 5 32. Ref strar's Signature	we !	- 110	11. 2 20032	

			1 - For State Registrar	State of Maryla		nent of Health and cate of Death		4000	16270
			Decedent's Name (First, Middle, La.	st)		outo or boutin	2. Date of Death	J. No.	3. Time of Death
	Physici		Eugone Fr	anklin S	tluka		Month	Day Year	1:20 PM
	/Medi Examir		4a. Facility Name (If not institution, give			City, Town, or Location of Dea		4c. County of Deat	
			University of M	aruland Medic	al Center	Baltimore		NIA	
	Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs	s. last birthday) If U	Inder 1 Year If Under 24 Hr		(ear) 9. Birt	hplace (State or Foreign
	Director		287-30-4614	ØM 2□ F	O / Yrs.	ions days from the	May 8	,1938	WI
	and		Usual Residence of Decedent  10a. State 10b. County	10c. C	city, Town or Location	1			10d. Inside City Limits
	daryl f sho	ō	1 1	1	n	Salic			1 ☑Yes 2 ☐ No
	the 286-	Director	10e. Street and Number	rungai	10	f. Zip Code	100	g. Citizen of What Co	untry?
	3e or		1300 Creday P	K RJ		21401	,	115	A
	death ms 2;	Funeral	11. Marital Status	12. Was Decedent Ever in	U.S. 13. Was E	Decedent of Hispanic Origin? ( specify Cuban, Mexican, Pue	Specify Yes or No-	14. Race - Ame	
ယ္	or Ite	Ē	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No W	ITINE		rto Rican, etc.)	Black, Whit	e, etc.
21215-0036	hours after death with the Maryland lurel', or Items 23e or 28e-f show al Examinat must be notified at	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 U Y	es 212-No Specify:		Specify:	white.
5-0	72 h	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a. Decedent's	Usual Occupation of work done during most of w	orkina 16	b. Kind of Business/	Industry
7	within lene the Med	ldm	Elementary/Secondary (0-12)	College (1-4or 5+)	`life. DO NO	OT use retired)		<del>-</del> .	,
7	filed w Hygie other th		10	4	1 120	glneer		Engine	zerino)
anc	be fi	Be	17. Father's Name (First, Middle, Last)	(+1	V	18. Mother's Na	me (First, Middle, Ma		)
Ĕ	should but Ment marked	2	100 Informatio Name (Belationship C		Na		hed H	augen	
Maryland	2 6 5 6		19a. Informant's Name/Relationship (	a wife	130. Mailing Add	dress (Street and Number or F	urai A ute ivumber, t	Dity or Newn, State, 2	(ID o MAC)
a)	1 and Health Iem 27 other tr		20a. Method of Disposition	101.00	Place of Disposition	(Name of	Date 20	oc. Losetion - City or	Town, State
D D			1 ☐ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specific		cemetery, crematory	or other place)	19-05 Y	3-14-	TAM
altimore,	구두면금		21. Signatur of Full ral Service Lic -	- 11	110 01	ne and Address # acility	11-05	uno,	MAIN
m	Department Department Important Impo		1 land	1 harch	ATT	Missa Mid	Valley D	TASS P T	18434
			23a. Parti-Enter the disease, or com- spock or heart failure. List only	plications that caused the dea	ath. Do not enter the	mode of dying, such as cardia	ac or respiratory arres	1,	Approximate Interval Between
	Physician	ē	Immediate Cause (Final disease or condition	Acres .		Carcinoma			Onset and Death
	/Medical		resulting in death)	Due to (or as a conse	equence of):	Carcinoma			1971
	Examiner		Sequentially list conditions	b					
	P iii	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	quence of):				
	and and -trans	Examln	that initiated events resulting in death) Last	cDue to (or as a conse	guence of				
8760,	cate be execul ohysician and the burial-trar			Due to (or as a conse	iquerice or).				
		dlcal	•	d					
9 x	death certific e attending p id for use as	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregr	nancy			23d. Date of deli	von.
Вох	death atter	ciar	in the past 12 months?	1 ☐ Live birth 2 ☐ Fel 4 ☐ Pregnant at time of		oic pregnancy or (specify)		Month	Day Year
0	the y th iche	Physician/Me	9 Unknown	9□ Unknown					
<u>ر</u> رو	taw requires that as been signed b 2 should be deta	by P	Part II. Other significant conditions c	ontributing to death but not re	sulting in the underly	ing cause given in Part I.	23e. Did toba	cco use contribute to	the cause of death?
ğ	w require been sig should b						1 ☐ Yes	2 □ No 3 Pro	bably 4 Unknown
Vital Records,	e taw re has be je 2 sho	Completed					24a. Was an	24b. Were au	topsy findings available ompletion of cause of
č	9 2 9	mo;					autopsy performe	d? death?	2 No
ita	Physicien: Th this certificate ral director, paç	Be (	25. Was case referred to medical examiner?			26. Place of De	ath Check on one		
<b>d</b>	Physic this o	ို	1 ☐ Yes 2 ☐ No		ER/Outpatient 3		Home 5 Residence	ce 6 □Other (Spec	ify)
n O		on:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how	injury occurred	
Sic	tend leath tor: the	cat	2 Accident investigation 3 Suicide 6 Could not be	On Physical Letter And	М	1 Yes 2 No	201 1 11 12		
Division	I or Atten after deat. Director;	Certification;	4  Homicide determined	28e. Place of Injury - At I building, etc. (Spec	nome, farm, street, fa ify)	ctory, office	City or Town, S	et and Number or Ru State)	ral Route Number,
_	spite nours nerel filled		29a. Certifier 1 Certifying Ph	ysician: To the best of my kn	lowledge, death occur	rred at the time, date and plac	e, and due to the cause	se(s) and manner as	stated.
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	edical	(Check only 2 Medical Exert one)	iner: On the basis of examin and manner stated.	ation and/or investiga	ation, in my opinion, death occ	urred at the time, date	and place, and due	to the cause(s)
	To the within To the Comp	Me	29b. Signature and title of certifier	4.4		29c. License number		. Date signed (Month	, Day, Year)
	. (		1Kn h	-MD		P18548	1	1ay 12	2005
	2X1		30. Name and address of person who	completed cause of death (Ite	m 23a) (Type, Print)	P18548 Green Street		1.1	
	0		Richard Ericson		South (	areen Street	Baltimo	R,MD	21201
	Sta Registr		31. Date filed (Month, Day, Year)	2. Registrar's Sign	-				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) For State Registrar **amend item 327&29c PFR PHY C843** 5/13/05 JH Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Physician Charles G. Stone 718 P M May 1 2-005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** University Baltimore Maryland N/A cit If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 6. Sex 1 ☑ M 2 ☐ F 8. Date of Birth Jan . 18, 1944 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 216-42-2453 61 Maryland Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f show permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryla Department of Health and Mental Hyglene.

Department of Health and Mental Hyglene.

In proporter: If item 27 is marked other than "neturel", or items 23a or 28e-1 show any injury or other treumatic event. It madical Evantment must be notified at once. 1 Yes 2 No Completed by Funeral Director Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1974 Poplar Ridge Road 21122 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) JP Food Service 12 Division President 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles G. Stone Sr. Heise ျှ Anna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gregory M. Stone (Son) 8248 Green Ice Drive, Pasadena, Maryland 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Loudon Park Cemetery 05-12-05 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fureral Service Licenses 22. Name and Address of Facility
McCully-Polyniak Funeral Home P.A.
3204 Mountain Road, Pasadena, Maryland 21122 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** COROMARY curtery disease /Medical Due to (or as a donsequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit ed by the attending physician and detached for use as the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 moorns?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown 9 Unknown s been signed by the should be detached Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed this certificate 20 No 1 Yes 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2√ No Certification; To 1 Thipatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral 28b. Time of 28c. Injury at Work? 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred XXNatural 5 Pending 1 Yes 2 No Accident investigation euld not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours a To the Funeral L Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the h 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number P17672 May 7 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 Baltmore MD 21201

State

Registrar

Evonne Pontamilla

MAY 1 3 2005

31. Date filed (Month, Day, Year)

S Green

22

Registrar's Signature

	1 - For State Registrar		ryland / De <i>C</i>	ertificate				•	Reg. No.		15	16	27
ysician	1. Decedent's Name (First, Middle, Las							2. Date of De Month		005	Year	3. Time	_
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aminer	4a. Facility Name (If not institution, give NATIONAL NAVAL		משיוואי	4b. City,	i own, or	Location of BETHE			4c.	_	of Death		
evol	5. Social Security Number 6. S		(In yrs. last birthda	(ay) If Under	1 Year	If Under 24		8. Date of Bir	th				e or Fo
eral ctor		□M 2⊠F	- Yrs.	Months	Days	Hours	Min. 22	8. Date of Bir (Month, Da May 6,	y, <u>Xear)</u>	5	Mary	place (State intry) Land	
	Usual Residence of Decedent												
1 L	10a. State 10b. County		10c. City, Town or									10d. Inside	City Lines 2 🛭
be notified Director	Maryland Montgo	mery	Bethe										9S Z <u>E</u>
Dir.	10e. Street and Number			10f. Zip		7			-		What Cou		
Funeral	5611 Oak Place	12. Was Decedent E	verin IIS 1		2081		in? (Spec	cify Ves or No				ates	
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by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2	2⊠ No	Specify:				Specify	/: W	hite	
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To To								a King					
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Jury	'4 □Donation 5 □ Other (Specify			ntgómei atorium			.005	29 AV				Mary.	
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page 2 should								24a. Was	an	24b. \	Were auto	psy finding	ıs avaıla
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director, page To Be Com	examiner?	Hospital: 1 Xapatien	t 2 ER/Outpat	ient 3 DO	Δ Othe			e 5 Resid		. □Oth	or (Speci	fic)	
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e fun atto	1 Accident S Pending		Year) Injur	M		? ′es 2 □ No	0						
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completely filled in Medical Cert	29a. Certifier 1 Sertifying Ph (Check only one)	ysician: To the best of niner: On the basis of and manner state	examination and/or	eath occurred a investigation,	at the tim in my op	e, date and inion, death	place, a	nd due to the d at the time,	cause(s) date and	and ma	nner as s and due t	stated. o the cause	)(s)
Me	29b. Signature and title of certifier	1 ()		29c	. License	number			29d. Dat	signe	d (Month,	Day, Year)	
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	30 Name and address of parson who	completed cause of de-	ath (Item 22a) (T	Print)		DECE		73 T . —	· - ~ -				
	30. Name and address of person who	completed cause of dea	ath (Item 23a) (Typ	e, Print)				VAL MEI 20889-			NTER		

amend item//19a, perfH, 6843, 5/13/05 TT
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** MOUSA TANNOUS MAY 11 2005 1:45 P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** COLUMBIA HOWARD 9167 HELAINE HAMLET WAY | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | J. Month. Days | Year | 924 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**Ø**M 2□F JERUSALEM 80 Yrs 085-48-8071 **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural; or Items 23a or 28a-f ehow 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits itam 27 is marked othar than "natural", or Itams 23a or 28a-1 ehow other traumatic evant, the Mcdical Examinar must be mytfled at 1 ☐ Yes 2 No Director HOWARD COLUMBIA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9167 HELAINE HAMLET WAY 21045 USA Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No WHITE Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MECHANIC **AUTOMOBILE** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be **TANNOUS** (UNOBTAINABLE) KHALIL MIRIAM ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9167 HELAINE HAMLET WAY - COLUMBIA, MD 21045 AIDA <del>TANNOUSA</del> WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ö Department of Important: If any injury or once. COLUMBIA MEMORIAL PARK 05/12/2005 COLUMBIA, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 10000 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Coronar /Medical **Examiner** Diabete w Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner use as the burial-transit To the Hospital or Attanding Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Probably 4 Unknown funeral director, page 2 should Be Completed 24a. Was an autopsy performs 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1□ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA 1 Yes 2.2No Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1.—Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 8775 cloudle apof #224, columbia MD212.045 CHARCE MEHTA. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

			Please	State of Marylan				•	•	
			1 - For State Registrer	Otate of Marylan		tificate of i		Reg.	2000	16071
		A	Decedent's Name (First, Middle, La	ist)				Date of Death		3. Time of Death
	Physici /Medio		Florenco T	erwische			0	Month	Day Year	5 1840 M
	Examir		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death		4c. County of De	ath
			The second secon	re Center		Boths	Sis.		sites	Je C. tu
	Funeral		5. Social Security Number 6. S	IDM 2XE	last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	Date of Birth (Month, Day, Ye	ar) C	rthplace (State or Foreign) Country)
	Director		212–18–5140 Usual Residence of Decedent	84	110.		J	an. 4, 1	921	Italy
	yland		10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
	a-f sl	ctor	Maryland		Baltim	ore City				1 X Yes 2 □ No
	72 hours after death with the Maryland haturel', or Items 23a or 28a-f show deal Examiner must be notified at	Funeral Director	10e. Street and Number			10f. Zip Code		10g.	Citizen of What C	Country?
	ath w	ra	436 Imla Street	T			21224		U.S.A.	
	Hem	in in	11. Marital Status  1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U. Armed Forces?  1 Yes 2 No	.5. 13.	Was Decedent of H f Yes, specify Cuba	ispanic Origin? (Speci in, Mexican, Puerto Ric	y Yes or No- can, etc.)	14. Race - Am Black, Wh	
21215-0036	urs aft	þ	30 Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1☐ Yes 2☐XNo	Specify:		Specify:	White
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Maryland	2 should be filed withir and Mental Hygiene. is marked other than eumatic event, II e M.	ဥ	19a. Informant's Name/Relationship (	(Type, Print)	19b. Mailir	ng Address (Street	and Number or Rural F		ty or Town, State.	Zip Code)
ĭ S	and 2 salth ar		Barbara Vavrina (	Daughter)	1	-	Poughkeeps.			
Je,	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If item 27 is marked other than "naturel", or Items 23a or 28a-f show or other treumatic event, If a Waited Examinating the mollified at		20a. Method of Disposition	20b. P		sition (Name of natory or other place		e 20c	Location - City o	
Ē	nit. Pages partment of l ortent: If its injury or o		1 X Burial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Speci	_Hemoval nom State		Mem. Par	inay io		ltimore,	Maryland
Baltimore,	permit. Pages 1 and 2 Department of Health Importent: If item 27 i any injury or other tre once.		21. Signature of Funeral Service Lice	7500						Home, P. A.
	0 □ □ ≈ 0		Quan	V. Luke			astern Ave.	700000000000000000000000000000000000000	ex, Mary	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	one cause on each line.	n. Do not ent	er the mode of dyin	g, such as cardiac or r	espiratory arrest,		Approximate Interval Between Onset and Death
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4	nd nd transi	Examiner	that initiated events	· Cholo	ngi	Ocaro	1000	λ		years
760,	e be executed rsician and burial-transit	cal Ex	resulting in death) Last	Due to (or as a conseq	uence of):)					9
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X 6	that the death certificate ed by the attending phys detached for use as the	/Me	IF FEMALE:	23c. If yes, outcome of pregna					23d. Date of de	alivery
Вох	death a atter d for u	ciar	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d		Ectopic pregnancy Other (specify)			Month	Day Year
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	The law requires that the death certificate ate has been signed by the attending physpage 2 should be detached for use as the	Completed by Physician/Medi	Part II. Other significant conditions		ulting in the u	nderlying cause giv	en in Part I.		1	to the cause of death?
ord	w requir been si should	ted	Today insu	sticience	1			1 🗆 Yes	2 <b>√</b> No 3□F	Probably 4 DUnknown
ec	e law has b	nple						24a. Was an autopsy performed	prior to	utopsy findings available completion of cause of
ᆵ	icien: The certificate rector, pag			T				1 ☐ Yes 2		s 2 No
of Vital Records,	Physicien: this certific ral director,	Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital: 1   Inpatient 2	ER/Outpatier	Oth	26. Place of Death (6		a 500 - 70	
of	ding Physicien: The I h. After this certificate ha funeral director, page	n: To	27. Manner of Death	28a. Date of Injury	28b. Time o	28c. Injur	v at 28	d. Describe how in	6 □Other (Sp njury occurred	ecity)
ion	ath. r: Afte	atlo	Natural 5 Pending 2 Accident investigation	(Month, Day Year)	lnjury	M 1 🗆	K? Yes 2 □No			
Division	r Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be determined		ome, farm, str	eet, factory, office	280	Location (Street City or Town, St		Rural Route Number,
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	To the Hospital or Attending I within 24 hours after death.  To the Funeral Director: Atter completely filled in by the funer	Medical		hysician: To the best of my kno miner: On the basis of examina and manner stated.						
	To the within 2 To the complet	Me	29b. Signature and title of certifier	and marrier stated.		29c. Licens	e number		Date signed (Mor	oth, Day, Year)
	/		NIJ ()	5 M		100	74383	17	ay 12	
•	h		30. Name and address of person who	completed cause of death (Item	n 23a) (Type,	Print) W.J.	bree noy	WILL WE	2- 2-	11 - 2
			32 Data filed (Month Day Yourd	PAC SSO	> HC	PKIN !	Buy ice	n Cica	de, ac	arisork
	Sta Regist		31. Date filed (Month, Day, Year) MAY 1 3 200	32. Registrar's Signa	Anas	is a	7			71997
			1 2 200.	CARREAL JU.	March					

Maria Vayghn

			1 - For State Registrar	State of	Marylan		artment rtificate			and M	lental Hyg	giene Reg. No. 0		16275
	Physici		Decedent's Name (First, Middle     Man			Vaugl	nan				2. Date of Dea Month	Day 7	Year 2005	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, Good Samar	, give street and num	. 1	1	4b. City, T		Location o		701 ory	4c. County	of Death	10.27
	Funeral Director				Age (In yrs. I.	ast birthday) Yrs.	If Under 1 Months		If Under 2 Hours		8. Date of Birth (Month, Day Aug 19	Year) , 1973	9. Birthp Coun Virg	lace (State or Foreign stry) Sinia
	Maryland I-f show fied at	tor	Usual Residence of Decedent  10a. State 10b. County  MD		1	, Town or Lo							1	0d. Inside City Limits 1 X Yes 2 □ No
	a with the	Funeral Director	10e. Street and Number 910 Biddle Stree	et			10f. Zip (	Code 1202				10g. Citizen of V	What Coun	try?
-0020	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Exam and the Lydified at ODGe.	by	11. Marital Status  1 X Never Married 2 Marri 3 Widowed 4 Divorced	12. Was Deced Armed Ford 1 Tyes 2 If Yes, Give Year or Dat	es? 2 (X) No		Was Decede If Yes, specif		spanic Orig n, Mexican Specify:	gin? (Spe , Puerto	acify Yes or No- Rican, etc.)	14. Rac Blac Specify	ce - Americ ck, White,	
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land 2	uld be filed Mental Hyg irked other	To Be C	17. Father's Name (First, Middle, L Melvin L. Vaug						18. Mothe Mo1		(First, Middle, Vaugha		7e)	
, Mary	and 2 sho		19a. Informant's Name/Relationsh Melvin L. Vaugh	( <del>-</del> -	her)						Church,		State, Zip	Code)
altimore	Pages 1 ament of He ant: If Item ury or oth		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp.		tate Fir Bap	ace of Dispo emetery crem St Mt. tist (	sition (Name matory or oth Oliv Church	e of her place 'e	)	5 <b>–</b> 14		20c. Location - Newtow		wn, State rginia
Dall	permit. Departi Import any inj		21. Signature Funeral Service L	bloch	200	/ I		ox 4	.76 T	appa	hannock			
	Fnysician /Medical	(	23a. Parf. Enter the disease, of shock, of heart failure. List of lamfiediate Cause (Final disease or condition resulting in death)		ch line.			_			n respiratory arr			Approximate Interval Between Onset and Death
٧,٥٥٠	re be executed ysician and e burial-transit	cal Examiner	Sequentially list conditions, we sting our reduce cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. <u>Sept</u> c. <u>Sept</u> Due to (o	TCSV	nance off: 100K ence of):								
O. DOX 00	o the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 brous effect death.  Of the Funeral Director: After this certificate has been signed by the attending physician and completely tilled in by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 DZ No 9 ☐ Unknown		th 2 □ Fetal nt at time of de	death 3□	Ectopic pred Other (spec			_		23d. Dat Mo	e of deliver	ry Day Year
Cido, r	quires that en signed b uld be deta		Part II. Other significant condition Respiratory	ns contributing to dea Failure	th but not resu	lting in the ur	nderlying cau	use giver	n in Part I.					e cause of death?
מים ומ	rsician: The law re s certificate has bee lirector, page 2 sho	Completed by	Anasarca	ia due -	to spii	nal s	chw	lan	nom	19	24a. Was a autops perform	med?	prior to com death?	osy findings available apletion of cause of
אווא וט	hysiclan this certifi al director	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No			ER/Outpatien		Other	n 4 □ Nur	sing Hon	Check onl on	ence 6 🗆 Oth		)
NOIS IN	To the Hospital or Attending Physician: The within 24 hours efter death.  To the Funeral Director: After this certificate his completely tilled in by the funeral director, page	Certification:	27. Manner of Death  1 Natural 5 Pending  2 Accident investig  3 Suicide 6 Could n  4 Homicide	ot be 28e. Place o	Day Year)  f Injury - At hor and the control of the		М		at ? es 2 □ N	lo	28d. Describe ho	reet and Numb		Route Number,
כ	To the Hospital or Attendi within 24 hours efter death. To the Funeral Director: A completely tilled in by the fu	ledical Cer	(Check only 2 Medical E	Physician: To the bear	is of examinati	vledge, death	occurred at	t the time	a, date and	l place, a	and due to the ca	ause(s) and ma	nner as sta	ited. the cause(s)
	To the within 2 To the complex	Med	29b. Signature and title of certifier	and manne	r stated.		29c.	License	number			9d. Date signed	i (Month, E	Day, Year)
	,		30. Name and address of person w			23а) (Туре, 1			000	1.1.		05/0	77/	2003
į	Sta		31. Date filed (Month, Day, Year)	ng 5601	LOCH distrar's Signatu	Ray	back	ol Va	, ba	1+11	nore.	MD	212	39
	Registr	ar	MATI	3 2005	MENON I	- 17								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrer	State of Maryland /	Department of H Certificate of		ental Hygiene Rag. No	GUU.	16276
	Physici /Medic		1. Decedent's Name (First, Middle, Las	st)	white		2. Date of Death Month Da May O	y Year 6 2005	3. Time of Death 1920 M
	Examin		4a. Facility Name (If not institution, give	14 cashal	4b. City, Town, o	r Location of Death	40	. County of Death	1
	Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs. last t	birthday) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Birth	place (State or Foreign
	Director	2	38-52-/973 1 Usual Residence of Decedent	□M 2XF 69	Yrs. Months Days	Hours Min.	8-4-35 8-4-35	5 Sou	th Carolina
	72 hours after death with the Maryland natural', or Items 23a or 28e-f ahow Jical Evanities must be notified at	_	10a. State 10b. County	10c. City, To	own or Location				10d. Inside City Limits 1 ☐ ♣s 2 ☐ No
	the Ma 28e-f	Director	10e. Street and Number	<u> Da</u>	10f. Zip Code		10g. Ci	tizen of What Co	
	th with 23a or sat be		724 E. Nors	4 Avenue	212	202	u	SA	Ĺ
	Items	Funeral	11. Marital Status  1 Never Married 2 Married	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No	13. Was Decedent of H	lispanic Origin? (Spe an, Mexican, Puerto I	cify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
5-0036	n 72 hours after death with the Marylan "naturel", or Items 23a or 28e-f ahow "noel Examinat he notified at	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ ★ No	Specify:		Specify: B	lack
215-(	iin 72 h n "natu	Completed	15. Decedent's Ed (Specify only highest gra	ducation 16 de completed)	Sa. Decedent's Usual Occup (Give kind of work done life. DO NOT use retired	pation during most of working d)	16b. K	(ind of Business/I	ndustry
2	be filed within 72 ho ital Hygiene. id other than "natui evant, II e Meulo	Com	Elementary/Secondary (0-12)	24Ears	Register	ed Nu	useJa	m Hopk	uns Hospite
Maryland	should be fi nd Mental H marked ott matic evar	То Ве	17. Father's Name (First, Middle, Last)	iu .	)	No Hi	(First, Middle, Maider	Sumame)	
<b>lary</b>	and and is m		19a. Informant's Name/Relationship (	778, Print) 15	9b. Mailing Address (Street		l Route Number, City	or Town, State, Z	ip Code)
_	1 an Healt tam 2		20a. Method of Disposition	Daughter 20b. Place	of Disposition (Name of	monn f	ate 20c. L	ocation - City or 1	7/2/3 Fown, State
altimore,	Page nent o ant: If ury or		1 Surial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		National (4	meters 11	3/05 6	usel,	MA
Balt	permit. Pag Department Important: I any injury o once.		21. Signature of Funeral Service Licer	fuit	22 Name and Address	Collection ?	ad Bal	the Ser	21212
			23a. Part1. Enter the disease, or com- shock, or heart failure. List only	plications that caused the death. Done cause on each line.	-		r respiratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a consequence		1.5mm	· · · · · · · · · · · · · · · · · · ·		One day
ı	Examiner		Sequentially list conditions,	b					
,	uted I Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequenc	ce of):				
Ö,	icate be executed physician and the burial-transit	Exa	that initiated events resulting in death) Last	Due to (or as a consequenc	ce of):			-	
68760	ficate b physic s the b	edicai		d					
Вох	eath certific attending p	an/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 manths?	23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal dea	ath 3 Ectopic pregnancy	y		23d. Date of deli	very Day Year
o.	The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as!	Physician/Med	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4☐ Pregnant at time of death 9☐ Unknown	5 Other (specify)			WOIT	Day Toal
Ф	es that igned b be deta		Part II. Other significant conditions of		, , ,	ven in Part I.			the cause of death?
ord	w require been sig should t	eted	Congestive	Heart Failure	•		1 ☐ Yes 2		
of Vital Records,	The law ete has page 2 s	Completed by					24a. Was an autopsy performed?	prior to c death?	topsy findings available ompletion of cause of
/ital	ician: Th certificete rector, pag	Be	25. Was case referred to medical examiner?	Homitali	044	26. Place of Death		,	
of	Physi er this c eral dire	1; To	1 ☐ Yes 2 ☑ No  27. Manner of Death		Outpatient 3 DOA Oth	4 🗆 Nursing Hor	ne 5 Residence 28d. Describe how inju		ify)
sion	anding sath. or: Afte he fune	ation	1 Natural 5 Pending 2 Accident investigation	1		rk?  Yes 2 □No			
Division	l or Att after de Direct	Certification;	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, office	2	28f. Location (Street as City or Town, State		ral Route Number,
	To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the tuneral director.	edical C	29a. Certifier 1 Cartifying Ph (Check only one) 2 Madicel Exar	ysician: To the best of my knowled niner: On the basis of examination and manner stated.	ige, death occurred at the til and/or investigation, in my o	me, date and place, a opinion, death occurre	and due to the cause(s ed at the time, date an	) and manner as d place, and due	stated. to the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier		29c. Licens			ite signed (Month	
,	2		30. Name and address of person who	completed cause of death (the sec	, -	5-000	ma	7:06,	2005
			Brack S. Sutten J.			urs Lounge.	1600 North Wu	ife street,	Baltimore, No 21287
	Sta Registi		31. Date filed (Month, Day, Year)	32. Registrar's Signature	4 Couls				
			MAYI	3 LUUD BROKES S	13				

		State of Maryland / Department of Health and	-	
		1 - State Registrar Certificate of Death		Reg. No. 005 16277
Physicia	n	1. Decedent's Name (First, Middle, Last)	2. Date of Da Month	Day Vana
/Medica	al	Daniel Edward Wisniewski  4a. Facility Name (If not institution, give street and number), 1 4b. City, Town, or Location of Deal	may	10 2005 7:00 A M
Examine	er	Franklin square Hospital Rosedale	>	BO-1+ more
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Min. Months Payer House Min.	. (Month, Da	h 9 Birtholago (State or Formige
Director		218 26 7096   180 M 2   F   71   Yrs.   World S   Days   Hours   Will   Usual Residence of Decedent	May 31,	1933 Maryland
yland		10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
he Ma	cto	Maryland Baltimore Middle River		1 ☐ Yes 2 ☑ No
15-0036  172 hours after death with the Maryland "neturel; or items 23e or 28e-f ehow edical Examination at matter relative at	Funeral Director	10e. Street and Number 6 Homeland Avenue 21 220		10g. Citizen of What Country?  USA
death death	nera	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (5 If Yes, specify Cuban, Mexican, Puer	Specify Yes or No	
0036 hours after urel; or ite		1 □ Never Married 2 ☑ Married 1 ☑ Yes 2 □ No If Yes, Give Korpan 1 □ Yes 2 ☑ No Specify:	nto mican, etc.)	Black, White, etc.  Specify: White
5-003(	ed by	15 Decedent's Education 18a Decedent's Usual Occupation		16b. Kind of Business/Industry
within 72 sene. The Medic	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  (Give kind of work done during most of woll life. DO NOT use retired)	orking	
d 212 filled with Hygiene ther their shirt.		2 Computer Technician	mo (First Middle	Baltimore, City  Maiden Sumame)
lanc	To Be	Unk. Alice	me (First, Middle,	Unk.
Maryland 212  A 2 should be filed within th and Mental Hygiene.  77 is marked other then traumatic event, the Mental Hygiene.	<b>-</b> 1	19a. Informant's Name/Relationship (Type, Print)  19b. Maiting Address (Street and Number or R		
re, M		Jane Wisniewski (Wife) 6 Homeland Avenue Bala	timore, I	
		20a. Method of Disposition  1 (XBurial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cametery, crematory or other place)  HOLLY Hill Mem. Gardens 5/		20c. Location - City or Town, State  Baltimore, Maryland
Baltimo		21. Signature of Funeral Service Licensee  22. Name and Address of Facility  Bruzdzinski Funeral  23. Name and Address of Facility		
Bal permi Depar Impor		1407 Old Fastern	Avenue Es	ssex. Md. 21221
		23a Fat1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia shock, or heart failure. List only one cause on each line.	c or respiratory ar	rest, Approximate Interval Between Onset and Death
Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)  a. A on a HSPI (at 1975)  Pue to (or as a consequence of):		
Examiner		SOUDE ONCOhania		
B #	iner	Sequentially list conditions, it any, leading to infinitely accuse. Enter Underlying Cause (Disease or injury that initiated events  C. Multiple Cause.		
sxecute	Examiner	that initiated events resulting in death) Last  C. Due to (or as a consequence of):		
	calE	a severe feritheral vascul	of Dis	(POSC
Box 68 sath certifica attending ph for use as th	Med	IF FEMALE:		
BO) Bath ce attend for us	cian/	23b. Was decedent pregnant in the past 12 months?		23d. Date of delivery  Month Day Year
P.O. nat the ded by the etached	Physician/Med	1   Yes 2   No 9   Unknown 9   Unknown		
	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	,	obacco use contribute to the cause of death?
requi	Completed		1/21	
Rec he law e has age 2 s	dmo			prior to completion of cause of death?
Vital Fideien: The certificate	BeC	25. Was case referred to medical 26. Place of De	1 ☐ Yes ath (Check only o	2 ☑ No 1 □ Yes 2 □ No ne)
of Vita Physicien: this certifici	٥		_	dence 6 Other (Specify)
On conding F	tion:	27. Manner of Death  1  Natural 5 Pending (Month, Day Year)  28a. Date of Injury 28b. Time of Injury 4 Work?  1  Accident investigation M 1 Year	28d. Describe h	now injury occurred
Division of Vital Records, To the Hospitel or Attending Physicien: The law requires t within 24 hours after death. To the Funeral Director: After this certificate has been signe completely filled in by the funeral director, page 2 should be	Certification:	2   Accident 3   Suicide 6   Could not be determined   28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (5 City or Tox	Street and Number or Rural Route Number,
Distribution of the property o		3		
Hosp 24 hou Fune etely fi	edical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place (Check only one)  1 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place (Check only one)		
To the within To the compli	Me	29b. Signature and title of certifier 29c. License number		29d. Date signed (Month, Day, Year)
• X		G. By Huchhorth po Resocoo		5/10/05
101		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Pr. J. Bry an Herchell out h 9000 Fron Klin 59 wore Print)  31. Date filed (Month, Day, Year)  32 Registrar's Signature	00	1+in-(- MD 21277
Stat	e	31. Date filed (Month, Day, Year)  MAY 1 3 2005  MAY 1 3 2005	V E 80	IIIIOIC, MY 2103
Registra	2.9	MAY 1 3 2005 Barre & Special		

	1 - For State Registrer	e of Maryland / Dep Ce	eartment of Health ertificate of Death		ienę <sub>eg. No</sub> 005	16278
Physician	Decedent's Name (First, Middle, Last)			2. Date of Deat Month	th Day Yea	3. Time of Death
/Medical	CLIFFORD L. WHIT			May	10 200	
Examiner	4a. Facility Name (If not institution, give street and	nd number)	4b. City, Town, or Location	of Death	4c. County of De	
Funeral	5. Social Security Number 6. Sex	7. Age (In yrs. last birthday	) If Under 1 Year If Under			irthplace (State or Foreign Country)
Director	191-12-6922 XX <sup>M</sup> <sup>2□</sup>	] F 80 Yrs.	Months Days Hours	Min. (Month, Day, 08/08/	1924 PE	NNSYLVANIA
pu	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or L	ocation			10d. Inside City Limits
Aaryia F sho	MD BALTIMORE	CATONS				1 ☐ Yes 2 € No
15-0036 n 72 hours after death with the Maryland "natural", or Itams 23a or 28a-f show salical Exercitivat Le notified at letted by Funeral Director	10e. Street and Number	CHIONE	10f. Zip Code	1	0g. Citizen of What (	
h with	1402 INGLESIDE AVI	ENUE	21207		USA	
(6 after death v or Itams 23s milher coust.	Arme	Decedent Ever in U.S. 13. ed Forces?	. Was Decedent of Hispanic Or If Yes, specify Cuban, Mexica	rigin? (Specify Yes or No- n, Puerto Rican, etc.)	14. Race - An Black, Wh	nerican Indian,
.0036 hours after tural; or ita	1 Never Married 2 Married 1 1	Yes 2 No USMC	1 ☐ Yes 2 No Specify.			LACK
hour hour	3 ☐ Widowed 4 ☐ Divorced Year  15. Decedent's Education	r or Dates:	edent's Usual Occupation		16b. Kind of Busines	s/Industry
215 Jun 72 Medic	(Specify only highest grade complete Elementary/Secondary (0-12)  Collete	eted) (Giv	e kind of work done during mos DO NOT use retired)	st of working		
nd 21215-00 e filed within 72 hou al Hygiene. to the than "naturn vant, if e Medical	12TH	SECU	RITY GUARD		LAW ENFO	RCEMENT
<b>77</b> = T = C	17. Father's Name (First, Middle, Last)			er's Name (First, Middle, I	Maiden Sumame)	
farylanc	HERMAN WHITE  19a. Informant's Name/Relationship (Type, Prin	d) 10b Mail	HILI		City or Town State	Zin Codo)
Mal d 2 st th and th and traum			INGLESIDE			
	20a. Method of Disposition	20b. Place of Disp	position (Name of ematory or other place)		20c. Location - City of	
MO Pages ent of ry or	Magazia	from State MD VET	י איבוים אוזכי כיבוא	5/17/2005	OWINGS M	TI.I.S. MD
Baltimore, permit. Pages 1 at Department of Hea Important: If item any injury or otha sone.	21. Signature of Funeral Service Licensee		22. Name and Address of Facili			OME 21207
<b>a</b> §§§§	// when	· Suy 4	600 LIBERTY	HEIGHTS A	VE., BAL	TIMORE, MD
	23a Part1 Enter the disease, or complications shock, or heart ailure. List only one cause	that caused the death. Do not er on each line.	nter the mode of dying, such as	s cardiac or respiratory arre	est,	Approximate Interval Between Onset and Death
Physician	Immediat ause (Final dis s r condition resulting in death)	Suptic Shock				Days
/Medical Examiner	Du Du	ue to ( r as a consequence of):	-C(			11
	Sequentially list conditions, b.	ia to (or as a nunsaquence of):	ttusion			Hours
b, executed in and ial-transit	Sequentially list conditions, 1 any, Lading to infiniodate cause. Enter Underlying Cause (Disease or injury that initiated events.	Luna Cancer				Months
	resulting in death) Last Du	ue to (or as a consequence of):				
8760, sate be executed by sician and the burial-transit dical Examin	d			· · · · · · · · · · · · · · · · · · ·		
as as a file	IF FEMALE:					
P.O. Box 6 that the death certific ed by the attending E detached for use as	23b. Was decedent pregnant in the past 12 months?		☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of d Month	elivery Day Year
P.O. Bc that the death that the death deathed for u	1  Yes 2  No 9 Unknown	Unknown	□ Other (specify)			
		g to death but not resulting in the	underlying cause given in Part	I. 23e. Did tob	bacco use contribute	to the cause of death?
rds,	Gastire Wen			1 □ Ye	es 2XNo 3□I	Probably 4 Unknown
Wital Records, sician: The law requires to certificate has been signer rector, page 2 should be of the completed by	ly on thy noidrsm			24a. Was a autops		autopsy findings available ocompletion of cause of
The I				perform	med? death?	
Vital Recipion: The law sician: The law sector, page 2	25. Was case referred to medical examiner?			e of Death (Check only on		
of Vita  of Vita  Physician: r this certific rral director,	1 ☐ Yes 2 No	1 Appatient 2 ER/Outpatie		ursing Home 5 Reside		ecify)
on of ding Phys After this funeral di	27. Manner of Death 28a.  1 Natural 5 Pending investigation	Date of Injury (Month, Day Year) 28b. Time Injury			ow injury occurred	
Division of Division of State death.  al Director: After the dineral of the function of the function.	2 Accident Investigation 3 Suicide 6 Could not be determined 28e.	Place of Injury - At home, farm, s		28f. Location (St	treet and Number or I	Rural Route Number,
Div	4 Homicide	building, etc. (Specify)		City or Towr	n, State)	
Division of Vital Red Division of Vital Red Division of Vital Red Mithin 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	29a. Certifier  (Check only 2 Medical Exeminer: On	To the best of my knowledge, dea	ath occurred at the time, date an	nd place, and due to the ca	ause(s) and manner	as stated.
tha Hospi in 24 hour tha Funar pletely fill		the basis of examination and/or i d manner stated.				
To t vith To t	29b. Signature and title of certifier	, to	29c. License number		9d. Date signed (Mo	
	Hay MStyphen	son MD	P17006	2 /	May 11 0	2002
6	30. Name and address of person who completed		enue Baltr	nou MD	•	
State	31. Date filed (Month, Day, Year)		1 de			
Registrar	MAY 1 3 2005	32. pegistrar's Signature	COAL			

			For State Registrar	State of Marylan	-	rtment of I			giene 005	16279
	Physici /Medic		1. Decedent's Name (First, Middle, Last)  ARREM	J. 1	VACI	KER		2. Date of De. Month	Day Year	3. Time of Death
	Examin		4a. Facility Name (If not institution, give stre Makyland Grenk	eet and number), RALHOSPI	tal	Baltin	or Location of Dea	ity	4c. County of Dea	2
	Funeral Director		212-84-8451	7. Age (Ih yrs.	last birthday) Yrs.	If Under 1 Year Months Days			1962 9. Bir	thplace (State or Foreign Duntry) MARY (AW)
2	the Maryland 28a-f show	lor	Usual Residence of Decedent  10a. State 10b. County	10c. Cit	ty, Town or Loc		IORE	CIT	· · · · · · · · · · · · · · · · · · ·	10d. Inside City Limits 1 ☑ Yes 2 ☐ No
Ker	with the 3a or 28a-	Funeral Director	10e. Street and Number 3609 BF/	E SUF	NIE	10f. Zip Code	1/2/5	-	10g. Citizen of What C	ountry?
2 get	72 hours after death with the Maryla "naturat", or Itams 23e or 28e-f show	by Funera	1 ☑ Never Married 2 ☐ Married	. Was Decedent Ever in U Armed Forces? 1  Yes 2 No If Yes, Give Year or Dates:		/as Decedent of I Yes, specify Cub	_	Specify Yes or No rto Rican, etc.)	14. Race - Am Black, Whi	
$\mathcal{U}_{\mathcal{U}}$		Completed b	3 Widowed 4 Divorced  15. Decedent's Educa (Specify only highest grade of	tion completed)	16a. Deced (Give I life. D	ent's Usual Occu kind of work done O NOT use retire	pation during most of weed)	orking	16b. Kind of Business	MORE CTY
212 pd	tilled within I Hygiene. other then "	Be Com	17. Father's Name (First, Middle, Last)	College (1-4or 5+)	WAT	ER I	18. Mother's Na	MENT ame (First, Middle,	PUBLT (	WORKS
$\mathcal{L}\mathcal{R}\mathcal{R}$ arvland	2 should be filed and Mental Hygi Is markad other aumatic event, I	ToB	19a. Informant's Name/Relationship (Type	WACKE o, Print)		Address (Street	t and Number or F	Rural Route Number	ar, City or Town, State,	Zip Code)
Ore. M	s 1 and if Health item 27 other tr		VIVIAN EVAN  20a. Method of Disposition  1 Ø Burial 2 □ Cremation 3 □ Ren	1 ,	Place of Dispos	atory or other pla	BELLE ace)	Date	20c. Location - City or	, MD 2/2/5 Town, State
Saltimore.	permit. Paga Department of Important: If eny injury or once.		' 4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee	///	7. 22	Name and Address	ess of Facility	HOWELL	13HCTI	MORE, MD
			23a. Party Epier the disease, or complica shook, or heart failure. List only one Immediate Cause (Final	ations that caused the deal cause on each line.	thi. Do pot ente	or the mode of dy	ing, such as cardi	ac or respiratory a	rrest,	Approximate Interval Between Onset and Death
	Physician /Medical Examiner		disease or condition resulting in death)	Due to (or as a consect	quence of):	unodeti	ciency	VIRUS	3	
d	ecuted and transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consec						
.8760.	icate be executed physician and sthe burial-transit	dicai E	d.	Due to (or as a consec	querice or).					
P.O. Box 68		Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of pregnation 1 ☐ Live birth 2 ☐ Fett 4 ☐ Pregnant at time of c	al death 3 🗌	Ectopic pregnand Other (specify)	су		23d. Date of de Month	livery Day Year
	quires that n sign <b>a</b> d b		Part II. Other significent conditions control  TRiCUSPIA Value	ibuting to death but not res	sulting in the un	derlying cause gi	A /	c :	obacco use contribute t res 2 □ No 3 □ P	o the cause of death?
Division of Vital Becords.	Tha law reate has bee	Completed by	Staeptocial B	acterem:	a '			24a. Was autor perio 1 V/Yes	an 24b. Were a prior to death?	utopsy findings available completion of cause of
Vita	ilcien: certific rector,	Be	25. Was case referred to medical examiner?	spital:		0:	thor	eath (Check only o		
of	ng Phys Iter this neral di	on: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju	4 🔲 Nursing		dence 6 Other (Spenow injury occurred	icity)
ojvisjo.	To the Hospitel or Attending Physicien: The law within 24 hours after death.  To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2.	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, stre	M 1	]Yes 2 □No	28f. Location ( City or To	Street and Number or R vn, State)	ural Route Number,
	Hospitel 24 hours a Funerel I etely filled	Medicai Ce	29a. Certifier (Check only one)  Certifying Physic Medical Examine	cien: To the best of my knor: On the basis of examination and manner stated.	owledge, death ation and/or inv	occurred at the t estigation, in my	time, date and plac opinion, death oc	ce, and due to the curred at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
	To the within To the comple	Me	29b. Signature and title of ortifier	) wu Si	na	29c. Licen	7 5 3 5	-	29d. Date signed (Mon	th, Day, Year)
	H		30. Name and address of person who com	ppleted cause of death (tree	m 23a) (Type, I	arula	nd G	enera	e Nospi	tal
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) MAY 1 3 2	32. Registrar's Sign		berte				

JRA	WINFIE	LD	State of Maryland /  1 - For State Registrar		artment rtificate			and M	ental Hy	giene Reg. Nö.	005	710	62	80
	District.		Decedent's Name (First, Middle, Last)						2. Date of De Month	ath Day	Y	ear :	3. Time o	of Death
	Physicia /Medic		Laura Virginia Winfield						MAY	-	005		2021	₽ м
	Examin		4a. Facility Name (If not institution, give street and number)				Location of			1	County of	Death		
			JOHNS HOPKINS HOSPITAL	10.1			RE CI				N/A			
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last b	Yrs.	If Under Months	Days	Hours	Min.	8. Date of Bi (Month, Di	ay, Year)	104	Country	e (State	or Foreign
	Director		Usual Residence of Decedent						Sept.	26,	194	2 Vi	rgi	nıa
	yland iow		10a. State 10b. County 10c. City, Total									10d.	. Inside (	City Limits
	Man 9-1 sh	tor	Maryland N/A E	3alt	cimor	e							1 <b>∑</b> Ye:	s 2∏No
	th with the 23a or 284 181 be not	al Direc	10e. Street and Number 230 Douglass Court		10f. Zip 21	Code 231				10g. Citi: US		at Country	n	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 Ia marked other than "neturel; or Items 23a or 28e-f show other traumatic event, the Medical Erams are must be notified at	Completed by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Xidowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 Xino If Yes, Give Year or Dates:	į .	Was Deced If Yes, spec 1 ☐ Yes 2			gin? (Spe i, Puerto I	cify Yes or No Rican, etc.)		Black,	American White, etc Blac	).	
2-0	netur	ted	15. Decedent's Education (Specify only highest grade completed)	a. Dece	dent's Usua	l Occupa	ation	t of worki	30	16b. Kii	nd of Busi	ness/Indus	stry	<del></del>
21	thin 7	nple	Elementary/Secondary (0-12) College (1-4or 5+)		kind of wor DO NOT us			i or workin						
S	ygien ygien ner th	Cor		Ious	sekee	pin						fami	ттХ	
ng	2 should be filed v and Menta! Hygie ! Ia marked other t raumatic event, II!	Be	17. Father's Name (First, Middle, Last) Early A. Lee						(First, Middle Sie J∈	-		,		
<u>S</u>	1 Mer narke	T <sub>o</sub>	The second secon	Ob. Admillio	na Addrone	(Ctroot o						tata Zi- Co	ada)	
Maryland	d 2 st th and 7 lan traun		Virginia Harrison/ Daughter						Route Numb					1213
ď	1 and Health tem 27 other tr		20a Method of Disposition 20b, Place	of Dispo	sition (Nam	e of		D	ate			ity or Town		
101	ages int of t: If it		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State  '4 ☐ Donation 5 ☐ Other (Specify)  Cente	-	matory or ot		1.0	$\frac{5}{1}/11$	/05			ie C		17.2
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr once.		21. Signature of Funeral Service Censee	22	2. Name and	Addres	s of Facility	y Cł	natmar n Rd E	-Ha	rris	Fun	era	1 Hom
			23a. Bart 1. Enter the disease, or complications that caused the death. Do										pproxima	
	×		shock, or heart failure. List only one cause on each line.								0 1	ln ln	iterval Be inset and	etween
	Enysician /Medical		Immediate Cause (Final disease or condition resulting in death)  Atthewoscievo		cav	aic	VUS	Luc	av IJ	Sea	50			
	Examiner			3 01).										
	- 58	Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	a of).								- 27		
/	outed id ansit	Examiner	Cause (Disease or injury that initiated events c.											
ó	an an rial-tr		resulting in death) Last Due to (or as a consequence	e of):		t								
8760,	ate be executed obysician and the burial-transit	ical	d											
9	ing ph as ti	Med	IF FEMALE:											
Вох	death certificate be executed e attending physician and od for use as the burial-transit	Physician/Medical	23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome or pregnancy 1 Live birth 2 Fetel deal		⊒Ectopic pre					2	3d. Date of Month	-	av	Year
0	the a	/sic	1 Yes 2 No 9 Wunknown 4 Pregnant at time of death	5 L	Other (spe	ecify)							,	
<u>a</u>	that the de ned by the a detached		Part II. Other significant conditions contributing to death but not resulting	in the u	ınderivina ca	luse give	n in Part I.		23e. Did	tobacco u	se contrib	ute to the o	cause of	death?
Records,	iaw requires that the as been signed by th 2 should be detache	ted by							10			☐ Probabl		nknown
ecc	e law r has be je 2 sh	Completed							24a. Was	DSV	pric	ore autopsy or to compl	findings letion of	available cause of
=	Th ate pag	Con							1 Yes	ormed? 2 X No	1 C	ath? Yes 2	] No	
Vital	ryaicien: Th	Be	25. Was case referred to medical examiner?  Hospital:					of Death	(Check only	one)				
of	d s	10	1X Yes 2 No 1 Inpatient 2XEH/C	Outpatien . Time of		_	4 🗀 140		ne 5 Res					
		on	1 Natural 5 Pending (Month, Day Year)	Injury	M	3c. Injury Work	rai (? Yes 2∐!		od. Describe	now injury	Occurred			
Division	ten leat tor: the	ical	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home,	farm str					8f. Location (	Street and	d Number	or Rural R	loute Nur	mber.
Θ	in the	Certification;	4 Homicide determined 286. Place of Injury - At nome, building, etc. (Specify)	,	1001, 100101)	, 000			City or To					
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by		29a. Certifier 1 ☐ Certifying Physician: To the best of my knowledge											
	n 24 h	edical	(Check only one) Medical Examiner: On the basis of examination a and manner stated.											(s)
	To the within To the comp	Me	29b. Signature and title of certifier	0	1		number					Month, Day		
)			I Carol Hallan we	\$	U	CME				M	AY 4	, 200	)	
	3		30. Name and address of person who completed cause of death (Item 23a	(Туре,	Print) 1	11 F	enn S	Stree	t Bal	timo	ce, M	lary1a	and :	21201
	Sta Registr		31. Date filed (Month, Day, Year) MAY 1 3 2005	Spe	de la									
				-										

		For State Registrar	State of Ma	aryland /		rtment of F tificate of		and Mer		iene	05	16281
Physic	an	1. Decedent's Name (First, Middle,	Last)						Date of Death Month 05		Year 05	3. Time of Death
/Medi	cal		Welsh			4h City Town o	a Langting a		05	4c. County		11:05aM
Exami	ner	4a. Facility Name (If not institution, Collington Epis		Care	,	4b. City, Town, o						George
Funeral			6. Sex 7. Age	(In yrs. last	birthday)	If Under 1 Year	If Under:		Date of Birth			place (State or Foreign
Director		282-38-4732	1 □ M 2XDF	89 	Yrs.	Months Days	Hours	MIII. 1	Date of Birth (Month, Day, .0-02-1	915	Mi	nnesota
land	]	Usual Residence of Decedent  10a. State 10b. County		10c. City, To	own or Loc	eation					1	Od. Inside City Limits
Maryl -fsho	to	MD Princ	e George	Mi	tchel	lville						1 ☐ Yes 2x No
h with the	Funeral Director	10e. Street and Number 10450 Lottsford		16		10f. Zip Code	2072	1	10	og. Citizen of \USA	What Cour	ntry?
Ind 21215-0036  be filed within 72 hours after death with the Maryland ital Hygiene. id other than "naturel", or flems 23a or 286-f show event, ire Medical Exercitational be retified at	þ	11. Marital Status  1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent I Armed Forces? od 1 Yes 2 M If Yes, Give Year or Dates:			Vas Decedent of H Yes, specify Cuba	lispanic Ori an, Mexican Specify:	gin? (Specify 1, Puerto Rica	Yes or No- an, etc.)		k, White,	ean Indian, etc. ite
215-0 Ithin 72 ho ie. Ian "natur IM dicall	Completed	15. Decedent'. (Specify only highest Elementary/Secondary (0-12)	s Education grade completed) College (1-4or 5		(Give I	ent's Usual Occup kind of work done OO NOT use retired	ation during most d)	t of working	1	16b. Kind of B	overi	
e filed Il Hygin other	Be	17. Father's Name (First, Middle, L	<u> </u>		GOVE	ETIMETIC			rst, Middle, M	faiden Suman		
rylan	2	Robbins Gilman  19a. Informant's Name/Relationsh	ip (Type, Print)	1	9b. Mailin	g Address (Street					State. Zio	Code)
and 2 s ealth an m 27 le i		Clement Welsh (			1045	0 Lottsf		Rd. Apt	3016	Mitche	11vi	lle MD
Baltimore, Marylar permit. Pages 1 and 2 should be Department of Health and Menta Important: If them 27 le marked amy lajury or other treumatic er once.		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (Sp		ceme	etery, crem	sition (Name of hatory or other plac ce Cremat		Date (ay 11		Beltsv		
Batt permit. Departi Imports any inj		21. Signature of Funeral Service L		06382	22. I	Name and Addre Rapp Fune 333 Gist	ss of Facilit eral & Ave S	y Crema Silver	tion S Spring	Service g MD 20	s 910	
Pnysician	0.3	23a. Part1. Enter the disease, or o shock, or heart failure. List o Immediate Cause (Final disease or condition	complications that caused inly one cause on each lin	10.		er the mode of dyir	ng, such as	cardiac or re	spiratory arre	st,		Approximate Interval Between Onset and Death 1 year
/Medical Examiner		resulting in death)	Due to (or as	a consequenc	ce of):							
hed nsit	nlner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Viscase or in jury	Due to (or as	a consequenc	ce of):							
18760, cate be executed physician and the burial-transit	Ical Examine	that initiated events resulting in death) Last	C. Due to (or as	a consequenc	ce of):							
687 tificate g phys as the	ed		d		-							
at the death certificate be executed by the attending physician and tached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal dea	ath 3 🗌	Ectopic pregnancy Other (specify)	/			23d. Dai Mo	e of delive	ery Day Year
- A P B	by	Part II. Other significant condition	ns contributing to death be	ut not resultin	g in the un	derlying cause giv	en in Part I.			_		ne cause of death? ably 4 \( \subseteq Unknown
€ 8 4 8 m	Completed							_	24a. Was an autopsy perform	ed?	orior to cor death?	psy findings available impletion of cause of
Vital sicien: T certificat irector, pa	O	25. Was case referred to medical					26. Place	of Death (C	heck only one			20110
- > O D	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatie		Outpatien	t 3□ DOA Oth	ier: 4 🔯 Nu	rsing Home	5 🗌 Resider	nce 6 □Oth	er (Specif	<i>(</i> )
Sing ling After	ion:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending		Y Year) 28t	b. Time of Injury	28c. Injur Wor M 1	yat k? Yes 2 ⊡1		Describe how	w injury occuri	red	
ivision attenter deat irector:	Certification:	2 Accident investig. 3 Suicide 6 Could n 4 Homicide determine	ot be One Place of Init	ury - At home, c. (Specify)	, farm, stre		163 2 0		Location (Str. City or Town,		er or Rura	l Route Number,
Hospite 4 hours Funeral	edical Ce		Physician: To the best of xaminer: On the basis of	examination								
To the within 2 To the complet	Med	29b. Signature and title of certifier	and manner sta			29c. Licens	e number		29	d. Date signe	d (Month,	Day, Year)
H3H0		1 ( de la	6	/		D250	79			05-04	4-200	5
15		30. Name and address of person v Don Yablonowit	z 7404 Excut	ive Pl	lace	Ste 502	Lanhai	m MD 2	0706			
St Regist	ate rar	Of Data filed (the st. Day Vose)	2005 Registra	ar's Signature	Spe	als)						

			- FOI	artment of Health and Menta	al Hygiene	16282
ı	°. Physici		1. Decedent's Name (First, Middle, Last)  ALVIN WILSON	2. Dat	te of Death	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, give street and number)  UMMS ADULT ER	4b. City, Town, or Location of Death  BALTIMORE, J	4c. County of I	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 48 Yrs.		te of Birth 9.	Birthplace (State or Foreign Country)
	Maryland f show	tor	Usual Residence of Decedent  10a. State  10b. County  10c. City, Town or Lo	cation TIMORE	, ,	10d. Inside City Limits 1 ☑ Yes 2 □ No
	h with the	al Director	10e. Street and Number 768 N GRANTIFY ST	10f. Zip Code 212-2-9	10g. Citizen of Wha	t Country?
920	be filed within 72 hours after death with the Maryland tal Hygiene. dother then "naturel", or Items 23e or 28e-1 show event, the Mediral Examina must be routhed at	by Funeral	1 Never Married 2 Married 1 Yes 2 X No	Vas Decedent of Hispanic Origin? (Specify Ye's Yes, specify Cuban, Mexican, Puerto Rican,		American Indian, White, etc. BLACK
21215-0036	C 2 30	Completed	(Specify only highest grade completed) (Give	ent's Usual Occupation kind of work done during most of working IO NOT use retired)  Electrician	16b. Kind of Busin	
Maryland 2	should be filed within on Mental Hygiene. marked other then imatic event, the M	ro Be Co	17. Father's Name (First, Middle, Last)  Jake Wilson		Middle, Maiden Sumame)	struction
	ith at 27 is r treu		Edith Raye Hughes/ Wife 768 N.	g Address (Street and Number or Rural Route Grantley Street Baltimore		te, Zip Code)
Baltimore,	00		20a. Method of Disposition  1 🗷 Burial 2 □ Cremation 3 □ Removal from State  1 □ Donation 5 □ Other (Specify)  20b. Place of Disposition cemetery, crem  Mt. Zion Cemetery	metery Date    Date   Date	20c. Location - City  Lansdowne	
Balt	permit. Pag Department Importent: I any injury o			Name and Address of Facility  lie Funeral Home P.A. 638	N. Gilmor St. Ba	altimore, MD21217
	rnysician /Medical		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a.  Due to (or as a consequence of):	1 1		Interval Between Onset and Death
8760, <	ate be executed hysician and he burial-transit	ical Examiner	Sacuantially set conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  C. Due to (or as a consequence of):	ncer		8
.O. Box 6	death certifica e attending ph d for use as th	Physician/Medi		Ectopic pregnancy Other (specify)	23d. Date of Month	delivery Day Year
rds, P	The law requires that the tee bas been signed by thoage 2 should be detached.	by	Part II. Other significant conditions contributing to death but not resulting in the un	derlying cause given in Part I. 23	te. Did tobacco use contribut	
Il Records,		Completed		_	a. Was an autopsy performed? deat	e autopsy findings available to completion of cause of h? Yes 2 \(\sumbole \text{No}\)
f Vital	Physician: Th this certificate ral director, pag	To Be (	25. Was case referred to medical examina?  1 Tes 2 No Hospital: 1 Inpatient 2 ER/Outpatient	26. Place of Death (Check t 3 DOA Other: 4 Nursing Home 5	k only one) ☐ Residence 6 ☐ Other (	Specify)
Division of	ng After		27. Manner of Death  1 Actival 5 Pending (Month, Day Year)  2 Accident investigation  3 Suicide 6 Could not be	28c. Injury at 28d. De Work? M 1 □ Yes 2 □ No	escribe how injury occurred	
Divi	in Sign	Certification;	4 Homicide determined 288. Place of Injury - At home, farm, streeth building, etc. (Specify)	City	cation (Street and Number o y or Town, State)	
	To the Hospitel within 24 hours a To the Funerel I completely filled	ledicai	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death a medical Examinar: On the basis of examination and/or invalid manner stated.	estigation, in my opinion, death occurred at the	e time, date and place, and	due to the cause(s)
	To the To the Complete	Σ	29b. Signature and title of certifier  Classical M	29c. License number D47322	29d. Date signed (M	onth, Day, Year)
	4		30. Name and address of person who completed cause of d <sub>2</sub> th (IT 23a) (Type, I HED I M TEAGUE 20	7 S-GREENES	T. BAUT	mD21201
	Sta Registi		31. Date filed (Month, Gay Year) 3 2005 32. Refistrar's Signature	parti		

			For State Registrar	State of Ma	ryland / Depa			ental Hyg	iene	005	16200
_					Ce	rtificate of L	Jeath	2. Date of Dea	eg. No.	000	10200
Н	Physici	an	1. Decedent's Name (First, Middle, Last					Month	Day	Year	3. Time of Death
4	/Medio	_	James Albert Zurk 4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death	05	10 4c. Co	2005 ounty of Death	8:30 PM M
	Examin	ier	3815 Memory Lane			Abingd			На	rford	
	Funeral		<ol><li>Social Security Number 6. Se</li></ol>	x 7. Age	(In yrs. last birthday)			8. Date of Birth (Month, Day			nplace (State or Foreign untry)
	Director		570-50-9067	<b>M</b> M 2□ F	64 Yrs.	Worting Days	110013	12/07/	1940	In	diana
	and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation					10d. Inside City Limits
	Maryl f sho	ō	MD Horefor		Abimada						1 ☐ Yes 2X No
	the 128e	rec	MD Harfor  10e. Street and Number	<u>a</u>	Abingdo	10f. Zip Code			10g. Citizer	n of What Co	untry?
	h with	ai D	3815 Memory Lane	e - Apt. D		21009			U.S	5. A.	
	ams	Funeral Director	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Span, Mexican, Puerto	ecify Yes or No- Rican, etc.)		Race - Ame	
36	72 hours after death with the Maryland naturel; or items 23a or 28e-f show Jical Examinar must be notified at	by Fu	1 Never Married 2 Married	1 X Yes 2 □ No If Yes, Give V 1 Year or Dates: T	etnam	1 ☐ Yes 2 X No	Specify:			necify:	
21215-0036	"naturei",		3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Ed		<del></del>	edent's Usual Occup	ation		16h Kind	Whi of Business/l	
15	within 72 ho piene. r than "natur the Medical	Completed	(Specify only highest grad	de completed)	(Give	kind of work done of DO NOT use retired	durina most of work	ing	TOD. PRING	or Dubinious.	industry.
212	d within giene. rr than *	mo;	Elementary/Secondary (0-12)	College (1-4or 5-		struction	1		Const	ructio	on Industry
	ba filed Ital Hygie of other	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle,	Maiden Su	ımame)	•
ylai		<u>ا</u>	Unknown				Mary Al	ice Zur	bruge	1	
Maryland	and and is m		19a. Informant's Name/Relationship (7		3815	ing Address (Street Memory L gdon, MD	and Number of Run ane Apt.	Dute Numbe	r, City or T	own, State, Z	Zip Code)
	1 an Heal		Joan H. Zurbruc	g (wife)	AD10 20b. Place of Disp			Date		tion - City or	
Baltimore,	0 0		1 XBurial 2 ☐ Cremation 3 ☐		cemetery, cre	matory or other plac	1				
量	그 투운공		<ul> <li>4 □ Donation 5 □ Other (Specify</li> <li>21. Signature of Funeral Service Licen</li> </ul>		Garrison	Forest Ve 2. Name and Addre	ss of Facility	12/2005 F Tage	OWING Taba	S MIL.	ls,Maryland l Home, P.A.
B	Department of the sany in pance.		PC IN X	22224-1							land 21087
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	dications that caused	the death. Do not er					1 2 2 2 2	Approximate Interval Between
J.	Pnysician		Immediate Cause (Final disease or condition	Acs	12	cardial ;	Frefreto	Line			Onset and Death
2	/Medical		resulting in death)	Due to (or as a	consequence o):	1 /	Franciscase				
П	Examiner		Sequentially list conditions,	b. Cari		rters d	isease				30 Jen-1
	ed sit	lhe	cause. Enter Underlying Cause (Disease or injury	Due to for as a	consquence of:						
	be exacuted sician and burial-transit	Examiner	that initiated events resulting in death) Last	C. Due to (or as a	consequence of):			<u> </u>			
8760,	The law requires that the death certificate be exacuted the has been signed by the attending physician and oase 2 should be detached for use as the burial-transit			d							
9	tificate og phys as the	Physician/Medical									
Вох	leath certifica attending ph	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of 1 Live birth		☐Ectopic pregnancy	У		23	d. Date of del	ivery Day Year
	e dea the at	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at : 9☐ Unknown	time of death 5	Other (specify)				Wioriai	Duy Feat
P.0	that the de led by the a detached		Part II. Other significant conditions of	notributing to death bu	t not resulting in the	underlying cause giv	ven in Part I.	23e. Did to	obacco use	contribute to	the cause of death?
Records,	signed I	d by	Chronic rona	1 2 2	failure	and only any data of gre		1 🗆 🗅	res 2 🗆	No 3□Pr	obably 4 Unknown
COL	w require baan sig should b	Completed						24a. Was	an	24b. Were at	utopsy findings available
Re	The law ate has page 2 s	m C						autor perfo	rmed?	prior to death?	completion of cause of
Vital		0	25. Was case referred to medical	· · · · · · · · · · · · · · · · · · ·			26. Place of Deal		2 <b>/S</b> No	1 🗆 Yes	2/2 NO
Ę	S S D	To B	examiner? 1 ☐ Yes 2 ∰ No	Hospital: 1  Inpatie	nt 2 ER/Outpatie	ent 3 DOA Ctt	ner: 4 Nursing Ho			□Other (Spe	city)
n of	ding Ph h. After th funeral		27. Manner of Death 1 SSNatural 5 ☐ Pending	28a. Date of Injur (Month, Day	y 28b. Time Year) Injury			28d. Describe I			
Siol	Attending r death. sector: After by the fune	catic	2 Accident investigation 3 Suicide 6 Could not be			M 1 🗆	Yes 2□No				
Division	or Atl	Certification:	4 Homicide determined	28e. Place of Inju- building, etc	ry · At home, farm, s . <i>(Specify)</i>	treet, factory, office		City or To		Number or Ri	ural Route Number,
	pitai		29a. Certifier 1  Certifying Ph	ysician: To the best of	f my knowledge, des	ath occurred at the ti	me_date and place	and due to the	cause(s) a	nd manner as	s stated
	24 hose Fun	Medical		niner: On the basis of and manner sta	examination and/or						
	To the Hospital or Attendi within 24 hours after death.  To the Funerel Director: A completely filled in by the fu	Me	29b. Signature and title of certifier	- 1-4	1," -	29c. Licens			29d. Date	-	h, Day, Year)
)	1/1		) W_	Attea	they mo	03	7016		Ma	12	, 2005
	10.41		30. Name and address of person who	4. ~0	6701 N.	(hwher )	L. Brit	Lox,	uns		
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) MAY 1 3	32. Registra	r's Signature	Sperke					

			For	State of Ma						ental Hy		•	10001	
		4	State Registrar			Cei	tificate	of Dea	th		Reg. No.	CUU.	16281	Richard I
	Physicia	an	Decedent's Name (First, Middle,	,						2. Date of Dea	Day	Year	3. Time of Death	
	/Medic		Christine Mitch				# 0' T-		- of Dooth	April	21	2005 County of Dea	3,000	
	Examin	er	4a. Facility Name (If not institution, of Heritage Harbour		Reha	ah	4b. City, 10	wn, or Location			40.	_	rundel	
	Funeral					st birthday)	If Under 1	Year If Und	der 24 Hrs.	8. Date of Birt (Month, Da	h Your		thplace (State or Foreig	jn
L	Director		225-03 <b>-</b> 9331	1□M <b>26</b> F	102	Yrs.	Months E	Days Hou	rs Min.	August			Virginia	
	pug *		Usual Residence of Decedent  10a. State 10b. County		10c. City.	Town or Lo	cation						10d. Inside City Limits	s
	Maryli	20		arundel				Anna	polis				1 ☐ Yes 2 🛣 No	
	r 28a-	rect	10e. Street and Number				10f. Zip Co	ode			10g. Citi	zen of What C	ountry?	
	th with	Funeral Director	213 Autumn Chase	Drive				2140	)1			U.S.A	i.	
	r dea	ner	11. Marital Status	12. Was Decedent I Armed Forces?		S. 13. \	Was Decedent f Yes, specify	nt of Hispanic Cuban, Mex	Origin? (Spe ican, Puerto	cify Yes or No Rican, etc.)	-	14. Race - Am Black, Whi		
36	rs afte	by Fi	1 Never Married 2 Married 3 Nover Married 3 Nover Married	d 1 ☐ Yes 2 🔯 N If Yes, Give Year or Dates:	No		1□Yes 2XX	MNo Spec	cify:			Specify: W	hite	
号	filed within 72 hours after death with the Maryland Hygiene. rthar than "natural", or Itams 23a or 28a-f show int, the Medical Examinar must be modified at	ted t	15. Decedent's	Education		16a. Dece	dent's Usual C	Occupation			16b. Ki	nd of Business	/Industry	
215	thin 7.	Be Completed	(Specify only highest Elementary/Secondary (0-12)	Grade completed)  College (1-4or 5	5+)	life.	kind of work of DO NOT use	retired)	nost of works	ng				
2	lygien har th	Co	6	2041		Asse	mbly L			(First, Middle,			acturing Co	Э.
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exeminet must be recitived any injury or other traumatic event, the Medical Exeminet must be recitived any once.	Be	17. Father's Name (First, Middle, La Eldee Mitchell							Hamlet		Sumame)		
2	shouk nd Me mark imatik	ဥ	19a. Informant's Name/Relationship	o (Type, Print)		19b. Mailir	ng Address (S	Street and Nu	mber or Rura	I Route Numbe	er, City o	r Town, State,	Zip Code)	
	and 2 alth a 127 ie		Nancy A. Colber	t/daughter		213	Autumn	Chase	Drive	a Annap	poli:	s, MD	21401	
Baltimore,	es 1 a of He fitam r oth		20a. Method of Disposition  12 ☐ Cremation 3	I □Removal from State	20b. Pla	ace of Dispo metery, crer	sition (Name natory or othe	of er place)		Date	20c. Lo	cation - City or	Town, State	
Ĕ	Pag tment tant: i		`4 □Donation 5 □ Other (Spe	cify)	Fort		Mem.		1	2005			Virginia	
Ball	permit Depar Impor Impor any in		21. Signature of Funeral Service Li	Censee Repmatel	Da.								al Home	
	202 60		23a. Part1. Enter the disease, or o	omplications that caused	the death.							aports,	MD 21401 Approximate	
	Physician		shock, or heart failure. List or Immediate Cause (Final			lootro	luto D	ni aordo					Interval Between Onset and Death	
	/Medical		disease or condition resulting in death)	Termin Due to (or as			TACE D	rsorde	<u>:</u>					
	Examiner		Sequentially list conditions,	<sub>b.</sub> Dehydr										
	sit ad	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequ	ence of j.								
	xecut and	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a consequ	ence of):								
760,	icate be executed physician and s the burial-transit	calE		d										
9			IF FEMALE:											
Вох	ath ce ttendii or use	lan/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1□Live birth	2 Fetal	death 3	Ectopic preg				2	23d. Date of de Month	llivery Day Year	
0	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as the	by Physician/Med	1 ☐ Yes 2 ፟፟፟፟፟፟ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	t time of de	ath 5	Other (spec	orfy)					,	
<u>α</u>	that ti	y Ph	Part II. Other significant condition	s contributing to death b	ut not resu	Iting in the u	nderlying cau	ise given in P	art I.	23e. Did t	obacco u	se contribute t	o the cause of death?	
Vital Records,	quires n sign uld be	q pe	Dementia							10	Yes 2	⊋No 3□P	robably 4 Unknow	n
000	aw requir is been si 2 should l	plet	Failure to T	hrive						24a. Was		24b. Were a	utopsy findings available	е
m m	ysician: The lav is certificate has director, page 2	Completed									rmed?	death? 1 ☐ Ye	completion of cause of s 2□ No	
/ita	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othor	lace of Death	n (Check only o	one)			
	<b>ਦ</b> ≑ ख	. To	1 Yes 2 No	28a. Date of Inju		R/Outpatier 28b. Time o	nt 3□ DOA			me 5 Resident			ecify)	
O	Attanding I r death. actor: After by the funer	tlon	1XXII 5 Pending 2 Accident investiga	(Month, Da	y Year)	Injury	М	c. Injury at Work? 1 ☐ Yes 2	i			,		
Division of	r Attano er death ractor: by the	Certification:	3 Suicide 6 Could no 4 Homicide determin		ury - At hor	me, farm, sti	reet, factory, o	office		28f. Location (S			fural Route Number,	
ō	ital or irs aftr ral Dir led in	Cer												
	To the Hospital or Attanwithin 24 hours after deall To the Funeral Director: completely filled in by the	edical	29a. Certifier Check only (Check only one)	Physician: To the best xaminer: On the basis of and manner sta	of my knov of examinati	vledge, deat ion and/or in	h occurred at vestigation, ir	the time, date n my opinion,	e and place, death occurr	and due to the ed at the time,	cause(s) date and	and manner a place, and du	s stated. e to the cause(s)	
	To tha within 2 To tha complet	Med	29b. Signature and title of certifie	and manner sta	ateu.		29c. l	License numb	per		29d. Dat	e signed (Mon	th, Day, Year)	_
)	r ≤ r ō		· MU	idah	$\wedge$	2		D5189	7		Арі	cil 25,	2005	
			30. Name and address of person w							-				
			Dr. Njide Udochi		olling			, #53	Caton	sville,	Mar	yland	21228	
	Sta Registi		31. Date filed (Month, Day Year)	2005 3 Registr	ar s Signar	THE STATE OF	all							
		iy.				N-1 C								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item 19b per fh 8843 5-13-05 vt. State of Maryland? Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) FEBRUARY 7, 2005 **Physician** EDITH VIRGINIA ASHENFELTER 5:03 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CUMBERLAND ALLEGANY CUMBERLAND NURSING HOME If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) FEB. 22,1913 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 🛛 F Months Days Hours Director 214-07-3601 91 WEST VIRGINIA Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits 10a, State 10b. County show ral', or items 23a or 28a-f shov Examiner must be notified at 1 Yes XXNo Be Completed by Funeral Director WV MINERAL RIDGELEY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 26753 U.S.A. ROUTE 3, BOX 385 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or lies may or other traumatic event, the Medical Exercipanty or other traumatic event, the Medical Exercipanty. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE 3 Widowed 4 □ Divorced al Hygiene. d other than \*natura event, the wedical E 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) FACTORY WORKER CELANESE FIBERS CORP. 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) MARY ANN ABE GEORGE SEYMORE BALDWIN ဥ 19b. Mailing Address (Street and 187 ber or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ROUTE 3, BOX #\*!, RIDGELEY, WV JAMES W. POWELL / NEPHEW 26753 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any injury or ot once. 1 Burial 2 □ Cremation 3 □ Removal from State 02/11/2005 ABE CEMETERY RIDGELEY, WV \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licen de 22 UPCHURCH FUNERAL HOME, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 202 GREENE STREET, CUMBERLAND, MD 215032 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Failure to Thrive Enysician 6-8 mall /Medical Due to (or as a consequence of): Examiner Renal insufficery Lew weeks Sequentially list conditions, if any, leading to immediate cause. Errer Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 DNo 4 Pregnant at time of death 5 Other (specify) P.0. detached 9 Unknown 9 ☐ Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Be Completed by Osteoaullium. Osteo porom 1 Yes 2 Mo 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 24 No of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 450 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: Division To the Hospital or Attending 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. Director: 6 Could not be 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2] Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Ama Scall MD

Registrar DHMH 17 Rev 1/2001

State

Kent AUR,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

625

32. Segistrar's Signature

Huma Shalal, MD

Day, Year)

MAY 1 3 2005

31. Date filed (Month

D46346

Ceenburland MD 21502

9, 2005

										3. Time of Dea		
Physici /Medio		Frances Ann Anderson							APRI L	- 22 .	2005	1445
Examir		4a. Fecility Name (If not institution, give street and number)  4b. City, Town, or Location of Death										
		Kernan Hospita  5. Social Security Number 6. Sec		s. last birthday)	Bal-		ore	24 Hrs.	Baltimore  8. Date of Birth 9. Birthplece			
Funeral Director		216-12-3941	M 2 1 88	Yrs.		Days	Hours	Min.	July I	Y, 1916	Mai	plece (State or Fo ntry) cyland
		Usual Residence of Decedent  10a. State 10b. County	100.4	City, Town or Lo	nation .							10d. Inside City L
n 72 hours after death with the Maryland "natural", or liems 23a or 28a-f show witch Estutier must be notified at	2	PA York		Spring		e						1 ☐ Yes 2
	rect	10e. Street and Number 10f. Zip Code						10g. Citizen o	f What Cou	ntry?		
	a Di	2996 Jefferso		17362					U.S.	Α.		
	Completed by Funeral Director	11. Marital Status  1 Never Mamied 2 Married  3 XWidowed 4 Divorced	I TYes 2 MNo If Yes, Give Year or Dates:  ducation  ade completed)  16a. Decec (Give		Was Decedent of Hispanic Origin? (Speci If Yes, specify Cuban, Mexican, Puerto Ri 1 Yes 2 No Specify:  edent's Usual Occupation  be kind of work done during most of working DO NOT use retired)			ecify Yes or N Rican, etc.)		14. Rece - American Indian, Black, White, etc.  Specify: White  16b. Kind of Business/Industry		
natur		15. Decedent's Edu (Specify only highest grad						ng	16b. Kind of			
	mple	Elementary/Secondary (0-12)			DO NOT use retired) eteria-Server				Manufactur		ring	
Hygie thar t	e Co	17. Father's Name (First, Middle, Last)		Car					First, Middle	e, Maiden Suma		
nd Mental marked o	To B	Frank Ross					Cat	her	rine Carttnio			
and is m sum		19a. Informant's Name/Relationship (Ty Claude W. Anderson								ber, City or Tow Windso:		
of Health Item 27 r other tr		20a. Method of Disposition	(	. Place of Dispo	osition (Name matory or oth	of er place,	)   7	Apri	Î25,	20c. Location	- City or T	own, State
ment of ant: If It ury or o		1 XBurial 2 ☐ Cremation 3 ☐ F  1 4 ☐ Donation 5 ☐ Other (Specify)	G	ardens o				200!	5	Balti		
Department of Important: If It any injury or o		25 Standature of Euro Vice Line America Line	far leustrig	MI 2						tenstei Freedo		tuary, 17349
nysician Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. MOCARDIAL INFARCTION						arrest,		Approximate Interval Betwee Onset and Dea		
xaminer			Due to (or as a consequence of):  CORONARY ARTERY DISEASE									
. 4	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):									
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ician burial		1	HYPERTENSION			1/		DICAL EXAMINER				
phys s the	adic	Due to (or as a consequence of):  HYPERTENSION:  IF FEMALE:  23b. Was decedent pregnant  23c. If yes, outcome of pregnancy  23d. Date of delivery										
ath certif ttending or use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time o 9 Unknown	etal death 3	⊒Ectopic preg ☐ Other (spec	gnancy	CERTIFIC		-		ate of deliv	ery Day Yea
n signed by the a uld be detached f	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  LEFT INTERTROCHANTERIC HIP FRACTURE  ANEMIA						23e. Did tobacco use contribute to the cause of deal				
s been s	Completed							24a. Was an autopsy findings ava				
ate has page 2	mo								peri	opsy ormed? 2 D No	death?	2 No
certificate ector, pag	Be	25. Was case referred to medical examiner?						of Death	(Check only			
this ca	ို	1 X Yes 2 1 No						Home 5 ☐ Residence 6 ☐ Other (Specify)				
h. After this certificate ha funeral director, page	lon	27. Manner of Death  ☐ Vatural 5 ☐ Pending  2 M Accident investigation	(Month, Day Year) Injury Work?				28d. Describe how injury occurred  Subject fell  28f. Location (Street and Number or Rural Route Number)					
ar death. actor: After by the fune	Certification;	ZM ACCIDENT										
I Dire	erti	4 Homicide	building, etc. (Specify)  Assisted living facility			S	28f. Location (Street and Number or Rural Route Number City or Town, State) Westminster, MI Surrecrville Hone, 45 Washii					
nera nera	Medical C	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best of my kiner: On the basis of examinand manner stated.	nowledge, deat	h occurred at	the time	e, date an nion, dea	d place,	and due to the	cause(s) and r	nanner as s	stated.Rd.
24 h e Fui	S =	29b. Signature and title of certifier			29c.	License	number			29d. Date sign	ed (Month,	Dey, Year)
within 24 hours after deatl To the Funeral Director: completely filled in by the		/1 /			1 7	The sec 17		2 -	i	Ail a		
within 24 hours after death  To the Funeral Diractor: completely filled in by the	-	1 monal	W M.D	),		DOF	212	11		04-21	5-20	205

RALPH L. BIGGS 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 4 2. Date of Death 1. Decedent's Name (First, Middle, Last) 27, 2005 APRIL **Physician** RALPH LEO BIGGS 0652 A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner HARFORD** HARFORD MEMORIAL HOSPITAL HAVRE DE GRACE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1**X**M 2□ F 220-52-6269 Yrs 57 1947 8, Maryland Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c, City, Town or Location 10a State 10b. County ir than "natural", or Items 23a or 28a-f show 1 Yes 2 No Harford Maryland Havre de Grace Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 107 George Court 21078 United States Pages 1 and 2 should be filed within 72 hours after death nent of Heatth and Mental Hygiene. Int: If item 27 is marked othar than "natural", or Items 236 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) unknown Food Service Worker Hospital 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Daniel Wesley Biggs Gertrude Elizabeth Presbury 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Arlene Biggs / niece Health itam 27 i 424 Middleton Lane, Aberdeen, Maryland 21001 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ita
any injury or ott 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
'4 ☐ Donation 5 ☐ Other (Specify) St. James United Cem. 5/5/05 Havre de Grace, MD 22. Name and Address of Facility
Lisa Scott Funeral Home, P.A.
552 Lewis Street, Havre de Grace, MD 21078
Approximate 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Chest Injunes /Medical Due to (or as a consequen of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Ursease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IE FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown þ signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed? 2 No 15 Yes 2□ No certificate 12KYes Hospital or Attanding Physician: 25. Was case referred to medical 26. Place of Death (Check only one, examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Yes 2 □ No this 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death Certification: After passenger i motor vehicle 1 Natural 2 ccident 5 Pending investigation 1 ☐ Yes 2 🗷 No death. April 27, 2005 5:50 A acides after death 6 Could not be 3 Suicide 2 e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 5B I-95, Aberdeen, MD filled in by 4 Homicide hylman within 24 hours a To the Funaral E 1 Certifying Physician: To the best of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mainer state. 29a. Certifier Medical completely (Check only one 29d. Date signed (Month, Day, Year) 29c. License number APRIL 28, 2005 O.C.M.E May Thee ND of person who completed cause of death (Item 23a) (Type, Print) 111 PENN STREET, BALTIMORE, MARYLAND 21201 1asha L Greenberg 31. Date filed (Month Registrar's Signature 2005 Registrar

		ı	1 - For State Registrar	• •	Maryland / De		Health and	Mental Hyg	_	5 1628	
- 1	Dhysisi		Decedent's Name (First, Middle, Last)					2. Date of Dea Month		3. Time of Death	
	Physici /Medic		Gwendolyn	Ann		Boland		April	23 2005 2005		
	Examin		4a. Facility Name (If not institution, g	er)		or Location of Dea	ith	4c. County of De Wicomic	4c. County of Deeth		
			Wicomico Nursing		-	Salisbu		s   0 0 · · · (D) · ·			
	Funeral Director		5. Social Security Number 069-16-8370  Usual Residence of Decedent	.Sex 7. 1 ☐ M 2 🖾 F	Age (In yrs. last birthd	Months Days			1920 No	lithplace (State or Foreign Country) ew York	
	land		10a. State 10b. County		10c. City, Town o	r Location				10d. Inside City Limits	
	Mary	ō	MD Washin	gton	Hagei	stown				1 X Yes 2 No	
	28a	Director	10e. Street and Number	8			10f. Zip Code		log. Citizen of What	Country?	
	3a o	i i	955 Noland Driv		21740			U.S.A.			
	deatl	Funerai	11. Marital Status	ent Ever in U.S.	in U.S. 13. Was Decedent of Hispanic Origin? (Sp tf Yes, specify Cuban, Mexican, Pueric			offy Yes or No- lican, etc.) 14. Race - American Indian, Black, White, etc.			
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f ehow any injury or other treumatic event, if a Medical Exacting must be notified at 2008.	þ	1 Never Mamed 2 Married 3 XWidowed 4 Divorced	∭No es:	1 ☐ Yes 2 🛣 No		itto i tiouri, dio.;	0	Thite		
9	72 ho	Completed	15. Decedent's (Specify only highest		16a. De	ecedent's Usual Occ Give kind of work don fe. DO NOT use retir	upation e during most of w	orkina	16b. Kind of Busines	ss/Industry	
21	en e	nple	Elementary/Secondary (0-12)	College (1-4	lor 5+)		red)		a 1 /m 1		
7	ed wi	Con	12		S	ecretary	T		Sales/Tel	evision	
Maryland 21215-0036	Juid be fill Jental H rked oth	To Be	17. Father's Name (First, Middle, La Louis A. Davis	ist)				ame (First, Middle, cet Wilson			
any	and h	2 0	19a. Informant's Name/Relationship	(Type, Print)	19b. M	lailing Address (Stree	et and Number or F	Rural Route Number	r, City or Town, State	, Zip Code)	
	and and a salth		Robert E. Boland	l/Son	The second second	Union Av			21801		
Baltimore,	of He fiter		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3	□ Removal from St	20b. Place of D cemetery,	isposition (Name of crematory or other p	lace)	Date	20c. Location - City	or Town, State	
Ĕ	Pag nent ant: J		'4 □Donation 5 □ Other (Spe		Rest Ha	ven Cemet	ery   4/2	26/2005	Hagerstown	ı, MD	
at	permit. Departr Importu any Inju		21. Signature of Funeral Service Lie	censee					Funeral (	-	
m	88 5 8		D. Warle Suy	Υ	gerstown,	MD 21742					
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (final disease or condition resulting in death)  Due to (or as a consequence of):								
68760,	iries that the death certificate be executed signed by the attending physicien and deetached for use as the burial-transit	Completed by Physician/Medical Examiner	d								
.O. Box	that the death certificed by the attending properties as		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	1 Live bir	ome of pregnancy th 2 Fetal death nt at time of death vn	3 □Ectopic pregnar 5 □ Other (specify)			23d. Date of c Month	delivery Day Year	
٥,	s tha med t	y P	Part II. Other significant condition	s contributing to dea	th but not resulting in the	ne underlying cause	given in Part I.			to the cause of death?	
rds	requires een sign	pa	CHENIC OBSTRUCTIVE PULMONARY LISEASE 10 Yes							2 No 3 Probably 4 Dunknown	
ပ္ပ	> <u>√</u>	ojet	ATRIAC FIBRICIATION 24a. Was an autops						24b. Were autopsy findings available prior to completion of cause of		
<b>e</b>	The la	E	Pilledanasay	TEN	FMROLISM			perfór	performed? death?  1 Yes 2 No 1 Yes 2 No		
ta	en: tifica tor, p	a	25. Was case referred to redical		VISUCISIVI		26. Place of D	eath (Check only or			
Division of Vital Records,	ding Physician: The lav h. After this certificate has funeral director, page 2	To B	examiner? 1 Tes 22 No	Hospital: Other				Home 5 ☐ Resid	dome 5 ☐ Residence 6 ☐ Other (Specify)		
0	g Ph er th eral		27. Manns of Death	28a. Date of	Injury 28b. Tin , Day Yeer) Inju	ne of 28c. In	of 28c. Injury at Work?		28d. Describe how injury occurred		
ō	ath. r: After	atio	1 ✓ Natural 5 ☐ Pending 2 ☐ Accident investiga	ition	n M 1 ☐ Yes			es 2 No			
<u>Vis</u>	Atte	£ 1	3 Suicide 6 Could no determin	200. Flace C	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
ā	s after or selection of the selection of	Certification;			9, 0.00 (0,000.))						
	To the Hospitel or Attendition 24 hours after death. To the Funerel Director: A completely filled in by the fu	edical (	29a. Certifier 1 Certifying (Check only 2 Medical E	ying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manne at Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and and manner stated.						as stated. lue to the cause(s)	
	To the To the To the To the Comp	Me	29b. Signature and title of certifier			29c. Lice	nse number		29d. Date signed (Mo	onth, Day, Year)	
			1/Mah 1	10-11.7	Mi	D	-00605	15	4/25/	05	
			30. Name and address of person w	ho completed cause			-000		1-1		
4	4-10		Mahesha Thimmar	ayappa, M			e Dr., S	alisbury,	MD 21804		
	St	ate	31. Date filed (Month, Day, Year)	7 200E 32. Re	strar's Signature	1					
	Regist		APR 2	£ 2005	Ever B.	porter					

DHMH 17 Rev 1/2001

CINTAIDOL YN

State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrat Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** April 2315 2005 Alice Geraldine Benton /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Hagerstown
Under 1 Year | If Under 24 Hrs.
onths | Days | Hours | Min. Washington County 8. Date of Birth (Month, Day, Year Jan 18 1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2XF Months 73 1932 Maryland Director Jan Usual Residence of December filad within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or Itams 23a or 28a-1 show traumatic event, the Medical Examinar must be notified at 1X Yes 2 □ No Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1000 Brinker Drive No: 102 21740 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 【XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XNo Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiena othar than " Elementary/Secondary (0-12) College (1-4or 5+) Homemaker s 1 and 2 should be fitad w f Health and Mental Hygier itam 27 is markad othar th Personal Residence 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ٩ Leon G. Colbourne Florence Avril Nichols 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health 1000 Brinker Drive Hagerstown Maryland 21740
be of Disposition (Name of Date 20c. Location - City or Town, State othar t Susan D. Benton (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 70 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) = 5 permit. Page Department of Important: If any injury or once. Cedar Lawn Memor Park Apr 27 05 Hagerstown Maryland 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licensee Mu 1331 Eastern Blvd. N. Hagerstown Maryland 21742 23a. Part1. Enter the deease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ongestive /Medical Due to (or as/a consequence of): **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 the attanding pt for use as t IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 4☐Pregnant at time of death P.O. bean signad by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records. tructive Dulingman 1 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed 2 No 1 Yes director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗹 No 1 🗌 Yes Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide vithin 24 hours a To the Funeral D 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 4-23-2005 1400 full 121457 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AVE. HAGERSTON. NID 21742 -12-821 -OAKHILL WATERD MM 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2005

			State of Maryland / Department of He.  1- State of Maryland / Department of He.  Certificate of Department of Department of He.		ental Hygie Reg.	4005	16290
			1. Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	Physicia		CHARLES CALVIN BOWERS		APRIL 2	Day Year 3 2005	8:30 A M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Lo			4c. County of Deeth	7 0.00 12
		ν.	21504 BLACK ROCK ROAD	HAGERSTO	WN	WASHI	NGTON
	Funeral		Months Days	Hours Min.	8. Date of Birth (Month, Day, Yo	9. Birthr	olace (State or Foreign ntry)
٠	Director		216-48-6876 124 2 57 Yrs. Usual Residence of Decedent		APRIL 19,	1948 M	ARYLAND
	and w		10a. State 10b. County 10c. City, Town or Location			1	10d. Inside City Limits
	Marylan -f show lied at	ō	MARYLAND WASHINGTON HAGERS	STOWN			1 ☐ Yes 2 📉 No
	r 28e	Director	10e. Street and Number 10f. Zip Code		10g	Citizen of What Cou	ntry?
	death with the Maryland ms 23a or 28e-f show r must be notified at		21504 BLACK ROCK ROAD 2	21740		U.S.A	•
	ems	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hisp If Yes, specify Cuban,	panic Origin? (Spe Mexican, Puerto I	cify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
20	n 72 hours after death with the Maryla "natural", or Items 23a or 28e-1 shov Lateal Exama na must be notified at	by Fu		Specify:		Specify: T.T.	HITE
2-0036	tural'		15 Decedent's Education 16a Decedent's Usual Occupation	ion	16	b. Kind of Business/In	
Ċ	in 72	piet	(Specify only highest grade completed) (Give kind of work done dur	ring most of workir	ng		
717	filed within 72 Hygiene. Ither than "nater, the Mode	Completed	Elementary/Secondary (0-12) College (1-4or 5+) EQUIPMENT	OPERATOR		EQUIPMENT	CONTRACTOR
	be file tal Hyg d othe	Bec			(First, Middle, Mai	iden Sumame)	
<u>Z</u>	Men Men arke	2		NETTIE W			
	0 = 0		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and			1	
	s 1 and f Health item 27 other to		YOLANDA BUTRICK/DAUGHTER 21504 BLACK RO  20a. Method of Disposition 20b. Place of Disposition (Name of			DWN, MARYL  Location - City or To	
و	0 = 5		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place)			rea sympeonic and a second	-01VVFROEAVZEE
			'4 □ Dopation 5 □ Other (Specify) CFDAR I AWN MEM. PAR  21. Signature of Fungial Service Licensee 22. Name and Address			AGERSTOWI, national P	
n	permit. Departi Import any inj		Paulm, Dean HAST FUNERAL	. HINNE		Maryland	21713
			23a. Part. Enter the dise as a complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line.				Approximate Interval Between
	hysician		Immediate Cause (Final NHULO MUE) CONVILLE	2 Mas	phil.	Interestina	Onset and Death
	/Medical		disease or condition resulting in death)  a. Due to (or as a consequence of):			- Traces	4-21/18
	Examiner		Sequentially list conditions. b. Hypuly dema				Yeyry.
	שָּׁ פּ	iner	if any, leading to immediate  Due to (or as a consequence or):				14 . 22 44 4
	and and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last c.  Due to (or as a onsequence of):	•			Y EIFIG
8/60,	cate be executed ohysician and the burial-transit		brain turnor.				YEARS
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XOR	eath certific attending p	N/	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of deliv	ery
ň	death e atte	icia	in the past 12 months?  1 Ves. 2 No.  4 Pregnant at time of death  5 Other (specify)			Month	Day Year
J.	at the de by the a	hys	9 Unknown		_		
Ś	res tha iigned l be det	by Physician/Me	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given	in Part I.		co use contribute to t	11
0	w require been sig should t	ted			· · · · · · · · · · · · · · · · · · ·		
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_	hysicien: The law his certificate has t i director, page 2 s				1 ☐ Yes 2 ☑	No 1 ☐ Yes	2 □ No
Vital	sicier certif recto	o Be	examiner? Hospital:	26. Place of Death		- C TOther (Creek	4.1
ō	Phys	H- 1	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury a	at 2	28d. Describe how	e 6 Other (Special injury occurred	y)
0	nding tth. :: Atte	ţ	1 Natural 5 □ Pending (Month, Day Year) Injury Work? 2 □ Accident investigation M 1 □ Ye	es 2□No			
Division of	Atte	Certification;	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	2	28f. Location (Stree City or Town, S	et and Number or Run State)	al Route Number,
<u></u>	itel or rs aft el Dir ied in	Cer		1			l)
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: Atter this certific completely titled in by the funeral director,	Medical	29a. Certifier  (Check only one)  2 Medical Examiner: On the basis of my knowledge, death occurred at the time, (Check only one)  and manner stated  and manner stated	e, date and place, a nion, death occurre	and due to the caused at the time, date	se(s) and manner as s and place, and due t	stated. o the cause(s)
	thin 2	Med	one) and manner stated.  29b. Signature and title of certifier 29c. License r	number	29d	. Date signed (Month,	Day, Year)
	⊢≯⊢ŏ		MPodul -	4571		April 25	1005
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	0301		1-1010 20	1 2003
51	1-16			AD H	HELLY TOW	N MO	21740.
	Sta		31. Date filed (Month, Day, Year) 5 2005 32. Registrar's Signature				
	Registi	ar	The state of the s				

		1 - For State Registrer	State of Mar	yland		rtment of H		nd Me	ntal Hygier	2000	16291
Physic	ian	1. Decedent's Name (First, Middle, La	•	-		-		2	Date of Death	Pay Year	3. Time of Death
/Medi	cal	Mary Kathleen B				th City Town or	I anatina of	Death		,	
Exami	ner	4a. Facility Name (If not institution, gi		Cent		4b. City, Town, or	T	OWSO	n		ltimore
Funeral Director		5. Social Security Number 6. 213–22–3386	Sex 7. Age (		st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	4 Hrs. 8 Min.	Date of Birth (Month, Day, Yea Nov.11,19	9. Bi 926 Ma	rthplace (State or Foreign Country) ryland
pu *		Usual Residence of Decedent  10a. State 10b. County	1	Oc. City.	Town or Lo	cation					10d. Inside City Limits
//anyla	ō	Maryland Washin				Hagerst	วพท				1 ☐ Yes 2 ☒ No
289-	Director	10e. Street and Number	80011			10f. Zip Code			10g. (	Citizen of What C	ountry?
h with		19941 Leitersbu	rg Pike				21742	2			USA
at y failed A I A I DOUGOO should be filed within 72 hours after death with the Maryland nd Mental Hyglene. I marked othar then "natural", or itams 23c or 28e-f show umatic event, the Medical Eventher mat be routified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:	er in U.S.	l I	Vas Decedent of Hi Yes, specify Cuba □ Yes 2⊠ No	ispanic Origi n, Mexican, Specify:	in? (Speci Puerto Ri	fy Yes or No- can, etc.)	14. Race - Am Black, Wh Specify:	
2 hour	edt	15. Decedent's B			16a. Deced	ent's Usual Occupa	ation		16b.	Kind of Busines	s/Industry
Paring 7. C	plet	(Specify only highest g. Elementary/Secondary (0-12)			(Give life. L	kind of work done o OO NOT use retired	during most o )	of working	'		·
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2 short and N is ma		19a. Informant's Name/Relationship				g Address (Street a					
Tand 1 and Health Bm 27 ther tr		Donna J. Barber  20a. Method of Disposition	- daughter	20h Pla		Ledwood D: sition (Name of	r., Ha	igers Dat		Location - City o	
Pages nent of int: If it		1 ☐ Burial 2 🖾 Cremation 3    '4 ☐ Donation 5 ☐ Other (Spec		cer	netery, cren	natory or other place n Cremate		4/22/	1,1		,Maryland
permit. Departn imports any inju		21. Signature of Fun and Barvice Lice	msee Mus	me	1	Name and Address					E yland 21740
Physician		23a. Till. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final	y one cause on each line.		Do not ente		g, such as ca				Approximate Interval Between Onset and Death YEARS
/Medical Examiner	П	disease or condition resulting in death)	Due to (or as a	conseque	ence of):						
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uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	MITRAL	REG	SURGI	TATION					WEEKS
cate be executed by sician and the burial-transit		resulting in death) Last	Due to (or as a			mr a mr					
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se as	0	IF FEMALE:	23c. If yes, outcome of	pregnan	~v					201 D-111	D.
The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	1 ☐ Live birth 2 4 ☐ Pregnant at tir	☐Fetal d	death 3□	Ectopic pregnancy Other (specify)				23d. Date of de Month	Day Year
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w require been sig should b	ompleted								24a. Was an	24b. Were a	utopsy findings available
The lay	amo du								autopsy performed/ 1 Yes 2 X i	prior to death?	completion of cause of
	BeC	25. Was case referred to medical examiner?					26. Place o	of Death (6	Check only one)		
Physic this ce	2	1 ☐ Yes 2 X No	Hospital: 1 ☐ Inpatient		R/Outpatien		4 🗀 Nurs		5 Residence		ecify)
Attending Physician: r death. sctor: After this certific by the funeral director,	lon;	27. Manner of Jath 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day )	(ear)	28b. Time of Injury	28c. Injury Work M 1 🗆	rat ⊲? Yes 2.⊟No		d. Describe how in	jury occurred	
Atteno death cctor: y the	ficat	2/Accident investigati 3 Suicide 6 Could not determine	be ago Blace of Injury	r - At horr	ne, farm, stre		103 2		f. Location (Street	and Number or F	Rural Route Number,
s after s afte	Certification;	4 Homicide	building, etc.	(Specify)					City or Town, Sta	ate)	
To the Hospitel or Attending Ph within 24 hours after death. To the Funarel Diractor: After thi completely filled in by the funeral.	edical (	29a. Certifier Certifying F (Check only one) Medical Exa	Physician: To the best of aminer: On the basis of each manner state	xaminatio	ledge, death on and/or inv	occurred at the time estigation, in my op	ne, date and pinion, death	place, and occurred	d due to the cause at the time, date a	(s) and manner a and place, and du	s stated. e to the cause(s)
To the To the comp	Me	29b. Signature and title of certifier	10-	4		29c. License	number		29d. [	Date signed (Mon	th, Day, Year)
		Kern	us (Freuell	MID		D 5	7329			4/2	0/05
Y1-3		30. Name and address of person who	/				1000 300 -	n, 1440. s. s.	E. de plan, come a	150	-
	ate	KERRY FREWITT  31. Date filed (Month, Play, Year),	M. D. 7		ire	R DRIVE	LOME	iUN,	MARYLA	ND 2120	Ţ
Regist		APR 25	2005 Some	-		whi					

			1- State of Maryland / Department of Health and N Certificate of Death		2005	16200
			Decedent's Name (First, Middle, Last)	2. Date of Deat		3. Time of Death
	Physici		Melinda G. Bowie	April 2	2005 Pear	05:18 a. <sup>™</sup>
	/Medio Examir		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death		4c. County of Deat	
			Prince George's Hospital Center Cheverly		Prince Ge	orgale
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day,		place (State or Foreign
	Director			April 17	, 1966 Mass	untry) Achusetts
	pu 🖈		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d Incide Objectively
	sho ed al	ō				10d. Inside City Limits 1 ☐ Yes 2 No
	28a-i	ect	Maryland   Prince George's   Hyattsville   10f. Zip Code		0. 0	
	with Ba or	ā	4104 VanBuren Street 20782		0g. Citizen of What Co J • S • A •	untry?
	leath	era			14. Race - Ame	ncan Indian
36	toges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If it item 27 is marked other than "natural", or itema 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 ☑ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:  1 ☐ Yes 2 ☑ No Specify:	Rican, etc.)	Black, White Specify: wh	e, etc.
21215-0036	2 hou	ed	15. Decedent's Education 16a. Decedent's Usual Occupation		16b. Kind of Business/	ndustry
215	nin 7.	Completed	(Specify only highest grade completed)  (Give kind of work done during most of work  Elementary/Secondary (0-12)  College (1-4or 5+)	ring		,
21	d with	E O	4 Federal Court House, Greenbe	1t I	J.S. Govern	nment
nd	al Hy al Hy d oth	Be (	17. Father's Name (First, Middle, Last)  18. Mother's Name	e (First, Middle, M	Maiden Sumame)	
<u>y</u>	should be filed with nd Mental Hygiene. I marked other than umatic event, Ine.	2		ly Lawrer	nce	
Maryland	2 sho and is mu		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rura  Molody, Lovyman and Mothers  (104, Name)			
	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than any injury or other traumatic event, If a Manace.		Melody Lawrence - Mother 4104 VanBuren Street, H	-		
סַ	Pages nent of P int: if its iry or o		1 ☐ Burial 2 Cemetery, crematory or other place)		20c. Location - City or	
Baltimore,	permit. Pages Department of Important: If i any Injury or c		*4 □ Donation       5 □ Other (Specify)       Metropolitan Crematory       April         21. Signature of Furrieral Service Licenses       22. Name and Address of Facility Gas		lexandria,	
Ba	permit. Departr imports any inj		4739 Baltimore Aven	ue,Hyatt	sville,Man	
١.			23a. Part 1. Enter the disease, or complications that a sed the death. Do not enter the mode of dying, such as cardiac of shock, of heart failure. List only one cause of a chine.	or respiratory arre	est,	Approximate Interval Between
	Prysician		Immediate-Eause (Final disease or condition resulting in death)  a. Mulmany Thrun Colubbilion			Onset and Death
	/Medical Examiner		Due to (or as a consequence of):	1		
	H	e	Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	y		
	uted d ansit	Examln	if any, leading to immediate cause. Enter Underlying Cause (Discussed or injury that initiated events c.	/		
o,	icate be executed physician and s the burial-transit	Еха	resulting in death) Last Due to (or as a consequence of):			
8760,	ate be nysici he bu	dlcal	d			
9	ing ph	Φ	IF FEMALE:			
Вох	eath certific attending p	lan/	23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 3 Ectopic pregnancy		23d. Date of deli	very Day Year
0	the a	Physician/M	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify)			34,
<b>Q</b>	that the ded by the detached		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23a. Did tob	acco use contribute to	the cause of death?
Records,	sign d be	d by		1 🗀 Yes	s 2 No 3 Pro	bably 4 Unknown
COL	w requ	lete		24a. Was an	24b Wara aud	anny findenan available
Re	The lay	ompleted		autopsy	prior to c ed? death?	opsy findings available ompletion of cause of
Vital		e Cc	25. Was case referred to medical 26. Place of Death		□ No 19 Yes	2 No
>	Physiclan: this certific ral director.	o B	examiner?			27
of		$\vdash$	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at	28d. Describe how	nce 6 Other (Spec winjury occurred	(y)
ion		atlo	1 ☐Natural 5 ☐ Pending (Month, Day Year) Injury Work? 2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No			
Division		Certification:	3 Suicide 6 Could not be	28f. Location (Stre City or Town,	eet and Number or Rui	al Route Number,
Ö	ital or A rs after ai Dire	Cer	duiding, att. (openly)	Only of Youn,	State)	
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	edical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a companient of the companient of the best of my knowledge, death occurred at the time, date and place, a companient of the companient of the best of my knowledge, death occurred at the time, date and place, a companient of the best of my knowledge, death occurred at the time, date and place, a companient of the best of my knowledge, death occurred at the time, date and place, a companient of the best of my knowledge, death occurred at the time, date and place, a companient of the best of my knowledge, death occurred at the time, date and place, a companient of the best of my knowledge, death occurred at the time, date and place, a companient of the best of my knowledge, death occurred at the time, date and place, a companient of the best of my knowledge, death occurred at the time, date and place, a companient of the best o	and due to the car red at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier 29c. License number	29	d. Date signed (Month	Day, Year)
)			Thoda M to day	Aı	pril 29, 20	005
R	(2)		30. Name and address of person who completed cause death (Item 23a) (Type, Print) Penn Street			
		13	THE OD ONE MINING	Datrillor	e, Marylan	G 21201
	Sta Registr	_	31. Date filed (Month, Day, Year)  MAY 0 2 2005  MAY 0 2 2005			
			MATUZ COUS MORE SE MATE			

			Please  1 - State Registrar	State of Marylar	nd / Depa		ealth and M	lental Hygi		16293
ì	Physicia		Decedent's Name (First, Middle, La	Mary Dolores B	rosenne	9		2. Date of Death Month April	30 2005 c	3. Time of Death 11: 45 A <sup>M</sup>
	/Medic Examin		4a. Fecility Name (If not institution, giv Ridgeway Manor No			4b. City, Town, or Catons	Location of Death		4c. County of Deetl	
	Funeral Director		216 01 3649	ex	. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, June 1,		nplace (State or Foreign untry) aryland
death with the Maryland	28a-f show	Director	Usuel Residence of Decedent  10a. State 10b. County  MD Baltim  10e. Street and Number		ity, Town or Lo			10	g. Citizen of What Co	10d. Inside City Limits 1 ☐ Yes 2 ☐ No untry?
death with	ital Hygiene. od other than "natural", or items 23a or 28a-f show event, the Medical Examination must be notified at	Funerai Dir	5743 Edmonson Ave	12. Was Decedent Ever in U Armed Forces?	J.S. 13.	2122 Was Decedent of Hi If Yes, specify Cuba		pecify Yes or No- Rican, etc.)	United St	rican Indian,
d Z1Z15-UU36	atural', or i	by	1 Never Married 2 Married 3 XWidowed 4 Divorced  15. Decedent's E	1 Yes 2 No If Yes, Give Year or Dates:	16a Dece	1 ☐ Yes 2 ☑ No	Specify:	cina 1	Specify: Wh	nite Industry
21212 2	Hygiene. ther then "n ent, the Med	Completed	(Specify only highest grader) Elementary/Secondary (0-12) 12	College (1-4or 5+)		kind of work done of DO NOT use retired utician			Self Emplo	oyed
aryland	is marked oth	To Be	17. Father's Name (First, Middle, Last Walter Resau	)			Anna Den			
Mar	eaith and n 27 is m		19a. Informant's Name/Relationship	ohew	119	200	antation	Stevensy	City or Town, State, 2 111e, MD 2 Oc. Location - City or	1666
Baltimore,	Department of H Important: If Ite any injury or ott once.		20a. Method of Disposition  1X Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Speci	Removal from State (fy)	cometery, cres	matory or other plac epherd Cer	m. 5-4-	-2005	Ellicott C	City, MD
Dai	Depart Import		21. Signature of Funeral Service Lice	~ ulth.	1	4112 Old (	Columbia	Pike Ell	icott City	nily FH Inc. v, MD 21043
	hysician		23a. Pert1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line.  Myocardia a			g, such as cardiac	or respiratory arre	si,	Interval Between Onset and Death Immediate
	/Medical xaminer	L	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conse		.,				
3760,		ical Examiner	if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	c						
O. BOX 68/		Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pregr 1 Live birth 2 Fel 4 Pregnant at time of 9 Unknown	tal death 3[	□Ectopic pregnancy □ Other (specify)			23d. Date of del Month	ivery Day Year
<b>1</b> 3	been signed by	by	Part II. Other significant conditions	contributing to death but not re	esulting in the u	underlying cause giv	en in Part I.		accoluse contribute to s 2. XNo 3 □ Pr	o the cause of death?
		Completed							y prior to death? No 1 □ Yes	utopsy findings available completion of cause of
or Vital	s certifi director	To Be	25. Was case referred to medical examiner?  1  Yes 2X No	Hospital: 1 ☐ Inpatient 2[	☐ ER/Outpatie	ent 3 DOA Oth	or	th (Check only one ome 5 Reside	e) nce 6 □Other (Spe	cify)
Division of	After funer	Certification: T	27. Manner of Death  1X Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not	28e. Place of Injury - At	home, farm, st	M 1 □	y at k? Yes 2 □ No	28d. Describe ho	reet and Number or Ri	ural Route Number,
ם מ	vithin 24 hours after deatl To the Funeral Director: completely filled in by the		4 Homicide determiner  29a. Certifier 1 Certifying P (Check only 2 Medical Exe	building, etc. (Special building) building buil	cify)nowledge, dear	th occurred at the tir	ne, date and place pinion, death occu	city or Town and due to the ca	use(s) and manner as	s stated. to the cause(s)
	within 24 To the F complete	Medical	29b. Signature and title of certifier	and manner stated.	- M.I	29c. Licens D233	e number		9d. Date signed (Mont	h, Dey, Year)
ر د	2		30. Name and address of person who Patrick W. White				Baltimore	, MD 212	-	
32	St	ate	31. Date filed (Month Oax Year) 2	2005 32. Redistrar's Sig	nature	1.0				

			State of M  For State Registrar AMEND#19 apperFH4/29/05, BMM  1. Decedent's Name (First, Middle, Last)	laryland / Depa v,McCo <i>Ce</i>	artment of H			eg. No. 4 0 0 0	16294
	Physici /Medio Examir	al	MEYER  4a. Facility Name (If not institution, give street and number)	ВАСН	4b. City, Town, or		APRIL 2	Day Year 26, 2005  4c. County of Deal MONTGOMER	7:45 P M
	Funeral Director		099-07-2854 ¹₺M 2□F	ge (In yrs. last birthday) 92 Yrs.	ROCKVIII	If Under 24 Hrs Hours Min		Year) 9. Birn	thplace (State or Foreign buntry) York
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. item 27 is marked other then "neturel", or Items 23e or 28e-f show other traumatic event, the Madical Exercities in at the natified at	by Funeral Director	Usual Residence of Decedent  10a. State  10b. County  MARYLAND  MONTGOMERY  10e. Street and Number  6111 MONTROSE ROAD, #410  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced  10b. County  12 Was Deceden Armed Forces 1 Yes, Give 1 Yes, Give Year or Dates:	] No				0g. Citizen of What Co UNITED ST  14. Race - Ame Black, White Specify:	CATES
nd 21215-0036	e filed within 72 hours at Hygiene other then "neturel" vent, the Manical Ex	Be Compieted b	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  8th Grade  17. Father's Name (First, Middle, Last)	16a. Dece (Give life.	edent's Usual Occup e kind of work done DO NOT use retired Lesman	during most of wo	me (First, Middle, I	•	/Industry
e, Maryland	i and 2 should be a Health and Mental am 27 is marked o the traumatic sve	To E	Isadore Bach  19a. Informant's Name/Relationship (Type, Print)  Elsa B. Carlton, M. D., Date 20a. Method of Disposition	ughter 10631	Weymouth	and Number or F	, Apt. 20	, City or Town, State, .	a, Md. 20814
Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: If item 27 Is eny injury or other tra	-	1 Derial 2 Cremation 3 Removal from State 4 Donation 9 Other (Specify)  21. Signature of Fineral Service Licensee	MT. LEBAI	NON CEMET  NON CEMET  Name and Addre  ANZANSKY	ERY 4/2	9/2005 A	ADELPHI, MA CHAPELS, LLLE, MD. 2	ARYLAND INC.
68760,	Physician /Medical Examiner	licai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	ad the death. Do not en line.  OSCLEROTIC is a consequence of):  PENSION is a consequence of):  is a consequence of):				951,	Approximate Interval Between Onset and Death
.O. Box 6	that the death certifical led by the attending phy detached for use as th	Physician/Med		2 Fetal death 3	□Ectopic pregnancy □ Other (specify)	1		23d. Date of de Month	livery Day Year
Records, P.	requires been sign should be	by	Part II. Dther significant conditions contributing to death MONOCLAVAL GAMMOPATHY O DEGENERATIVE JOINT DISE	F UNCERTAIN			1 □ Ye 24a. Was a	n 24b. Were a	robably 4 Unknown
Vital Re	icien: The law certificate has b rector, page 2 sl	e Completed	PEPTIC ULCER DISEASE  25. Was case referred to medical			26. Place of De	autops perform 1 ☐ Yes	med? death? 2 No 1 ☐ Yes	completion of cause of 2 □ No
Division of Vi	ding Phys	Certification; To B	examiner?  1 Yes 2 No Hospital: 1 Inpa  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined determined  28e. Place of I building, or contact the building, or contact the co	jury 28b. Time o	of 28c. Injur Wor M 1 🗆	4   Nursing	28d. Describe ho	ence 6 Other (Special or of River) or River and Number or River, State)	
	Hospite 24 hours Funeral tely filled	edicai Cer	29a. Certifying Physician: To the besic phee 2 Medical Examiner: On the basis and manner:	of examination and/or in	ath occurred at the time	me, date and place opinion, death occ	e, and due to the courred at the time, d	ause(s) and manner a ate and place, and due	s stated. a to the cause(s)
)		Med	29b. Signature and title of certifier		29c. Licens			9d. Date signed (Moni	
	12		30. Name and address of person who completed cause of GARY RAFFEL, D.O., 5411 W.	. CEDAR LAN	E, #202A	BETHESI	A, MARYLA	AND 20814	
	St Regist	ate rar	31. Date filed (Month Pay Year) 9 2005	strar's Signature	parti				

			1- For State of Maryland / Dep Registrar Ce	artment of Health and Nertificate of Death		ene2005	16295
	Physici /Medi		Decedent's Name (First, Middle, Last)  LAWRENCE ALOYSIUS BARRY		2. Date of Death Month MAY 7	Day Year 2005	3. Time of Death 4:30 A M
.X.	Examir		4a. Facility Name (If not institution, give street and number) EGLE NURSING HOME	4b. City, Town, or Location of Death LONACONING		4c. County of Dear	th
	. Funeral Director		5. Social Security Number 6. Sex 1. Age (In yrs. last birthday of	Months Days Hours Min.	8. Date of Birth (Month, Day, You MAY 23 19	9. Bin	thplace (State or Foreign cuntry) RYLAND
	e Maryland Se-f show tifled at	ctor	Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or L           MARYLAND         ALLEGANY         FROSTBU				10d. Inside City Limits 11 Yes 2 □ No
	h with th	Il Directo	10e. Street and Number 153 S. WATER STREET	10f. Zip Code 21532	10g	Citizen of What Co	ountry?
036	be filed within 72 hours after death with the Maryland ntat tygiene. st other then "neturel", or ttems 23c or 28e-1 ehow event, it e Madical Exerciting to notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 XWidowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 🎇 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify:	
21215-0036	C * 3	Completed	(Specify only highest grade completed) (Give life.	dent's Usual Occupation kind of work done during most of work DO NOT use retired)	ing	b. Kind of Business/	,
	should be filed within of Mental Hygiene. marked other then metic event, It a M	Be Co	17. Father's Name (First, Middle, Last)	L FINISH INSPECTOR  18. Mother's Name	e (First, Middle, Mai	TIRE BUIL den Sumame)	DING
Maryland	should be nd Mental marked o	To	JAMES BARRY  19a. Informant's Name/Relationship (Type, Print)  19b. Maili	CLARA ng Address (Street and Number or Rura	SMITH	its or Town State 3	7:- 0- 4-1
	and 2 sealth arm 27 is		ROBERT F. BARRY / SON 220	McCULLOH STREET,	FROSTBURG		
timore,	Pages 1 nent of H nnt: If ite ury or ott		20a. Method of Disposition  1 X Burial 2 ☐ Cremation 3 ☐ Removal from State  20b. Place of Disposition cemetery, cremation.	osition (Name of matory or other place) AEL'S CEMETERY 5/1	Date 200	OSTBURG,	Town, State
Baltii	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 Is marked any injury or other traumetic en 2015.		21. Signature of Funeral Service Licensee	2. Name and Address of Facility  DWERS FUNERAL HOME	6	O W. MAIN ROSTBURG,	STREET
	Pnysician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)	er the mode of dying, such as cardiac of	or respiratory arrest,		Approximate Interval Between Onset and Death
	Examiner		Due to (or as a consequence of):  Sequentially list conditions.	elyobration			
LT.	ecuted and -transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):	to take oral	Hind	5	()
68760,	ficate be executed physician and is the burial-transit	edical E	d. Metabr	he encepha	lopathy	ı	2 Weeks
P.O. Box	The law requires that the death certificate has been signed by the attending cage 2 should be detached for use as	Physician/M		]Ectopic pregnancy ] Other <i>(specify)</i>		23d. Date of delin Month	very Day Year
Vital Records, P	w requires that been signed t should be det	by	Part II. Other significant conditions contributing to death but not resulting in the understanding the significant conditions contributing to death but not resulting in the understanding the significant conditions contributing to death but not resulting in the understanding the significant conditions contributing to death but not resulting in the understanding to death but not resulting to death but not result not resulting to death but not resulting t	nderlying cause given in Part I.	23e. Did tobacc	• •	the cause of death?
Kecc	The law rate has be page 2 sh	Completed	Hypertensian.		24a. Was an autopsy performed	prior to co	topsy findings available ompletion of cause of
/Ital		Be Co	25. Was case referred to medical examiner?	26. Place of Death	1 Yes 2	No 1 ☐ Yes	2 🕱 No
Division of \	g Physer this eral di	atlon: To	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatien  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation  Hospital: 1 Inpatient 2 ER/Outpatien  28a. Date of Injury (Month, Day Year)  28b. Time of Injury		me 5 ☐ Residence 28d. Describe how in		ity)
DIVIS	after des Directo	ertification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, stribuilding, etc. (Specify)	et, factory, office	28f. Location (Street City or Town, St	and Number or Rur ate)	al Route Number,
	To the Hospitel or Attendin within 24 hours after death. To the Funerel Director: Alt completely filled in by the fun	edical C	29a. Certifier (Check only one)  1 Certifying Physicien: To the best of my knowledge, death 2 Medicel Exeminer: On the basis of examination and/or invand manner stated.	occurred at the time, date and place, a restigation, in my opinion, death occurred	and due to the cause ad at the time, date a	(s) and manner as and place, and due to	stated. to the cause(s)
	To t To t	W	29b. Signature and title of certifier  SL Janudlur MW	29c. License number D 14464		Date signed (Month, $5/09/2$	Day, Year)
	4		30. Name and address of person who completed cause of death (Item 23a) (Type, S. L. SANDHTR. M. D. 48 TARN TERI		D 21522		
(10)	Stat Registra	e ar	S. L. SANDHIR, M. D. 48 TARN TERM 31. Date filed (Month) 34 (Month) 32005 32. Legistrar's Signature 32005	old	1		

Director   A part   Thomas				1 - For State Registrar	State of Man		artment rtificate			_	ene	5	162	96
Homewood at Williamsport  Williamsport  Williamsport  Williamsport  Williamsport  222-07-2419  Williamsport  232-07-2419  Williamsport  232-07-2419  Williamsport  Williamsport  100-000000000000000000000000000000000				1. Decedent's Name (First, Middle, Last	)					2. Date of Death			3. Time of	Death
Homewood at Williamsport  Williamsport  Williamsport  Williamsport  Williamsport  222-07-2419  Williamsport  232-07-2419  Williamsport  232-07-2419  Williamsport  Williamsport  100-000000000000000000000000000000000				JAY THO	MAS	CLOUD				April 2	1, 2005	<b>Year</b>	5:10	м. А
Second Bookery Number   Seco				· · · · · · · · · · · · · · · · · · ·	· ·		4b. City, T	own, or Loc	cation of Death		4c. County of	Death		
Provided   Provided Community   Provided Communit											Was	hin	gton	
The Court of the				***						8. Date of Birth (Month, Day,	Year)	9. Birthpl	ace (State o	r Foreign
The control of the						) / 115.				April 9,	1918	lenn	essee	
Thomas and the property of the		yland			10	c. City, Town or L	ocation					10	Od. Inside Cit	ty Limits
Thomas and the property of the		B-1 s	ctor	Maryland Washin	gton	Wi]	liams	port	;				1 🗀 Yes	2 X No
Thomas and the property of the		or 28	Jire				10f. Zip C	ode		10	g. Citizen of Wh	at Count	try?	
Thomas and the property of the		ath w		16505 Virginia	Avenue						U.S.	Α.		
Thomas and the property of the		er de	une		Armed Forces?	r in U.S. 13.	Was Decede If Yes, specif	nt of Hispan y Cuban, N	nic Origin? (Sp lexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Black	America White, e	an Indian,	
Thomas and the property of the	36	rs aft	oy F		1 X Yes 2 □ No If Yes, Give									
Thomas and the property of the	Ö	2 hou	ted	15. Decedent's Edu	cation	16a, Dece	dent's Usual	Occupation	1	10	6h Kind of Busi			
Thomas and the property of the	215	hin 7: 8. Medi	pie	(Specify only highest grad	e completed)	(Give	kind of work DO NOT use	done durin retired)	g most of work	ing	ob. Kind of busi	11033/1110	ustry	
Thomas   Nathan   Cloud   Victoria   Wolfe   Substitution   Wolfe   Substitution   Wolfe   Substitution   Wolfe   Substitution   Wolfe   Wol	21	ad wit	Con			Ele	ctric	ial	Engine	eer	Utility			
Thomas   Nathan   Cloud   Victoria   Wolfe   Substitution   Wolfe   Substitution   Wolfe   Substitution   Wolfe   Substitution   Wolfe   Wol	lnd	be fill Hy d oth	Be					18.	Mother's Name	e (First, Middle, Ma	aiden Sumame)			
4 Dast Antietam Street, Hagerstown Md. 21740  Physician Medical Examinor  Physician Me	<u></u>	nould I Men narke natic	To											
4 Dast Antietam Street, Hagerstown Md. 21740  Physician Medical Examinor  Physician Me	Mai	d 2 st th and 7 is n traun												
4 Dast Antietam Street, Hagerstown Md. 21740  Physician Medical Examinor  Physician Me	ė,	1 and Healt sem 2				20b. Place of Dispo	Sition (Name	and P.						43
4 Dast Antietam Street, Hagerstown Md. 21740  Physician Medical Examinor  Physician Me	10	ages ant of it: if if		1 ☐ Burial 2 🛣 Cremation 3 ☐ F	dilioval ligiti State							•		
4 Dast Antietam Street, Hagerstown Md. 21740  Physician Medical Examinor  Physician Me	alti.	ortan									igerstow	n, M	∥ary⊥a	nd
Physician Physic	ñ	Per Imp		R. hoel Br	ady		Indrew 10 East	K. Co : Anti	offman   letam S	Funeral H treet Ha	lome, Ir	ic.	/d 21	740
Physician Medical Examiner  The display of the condition				23a. Part1. Enter the disease, or complishook, or heart failure. List only or	cations that caused the	death. Do not ent	er the mode	of dying, su	ich as cardiac o	or respiratory arres	t,		Approximate	)
Due to (or as a consequence of):    Due to (or as a consequence of):		Physician		Immediate Cause (Final disease or condition		Place	de	Cn.	100					
State    Sequentially list conditions   Sequentially list cond				resulting in death)	Due to (or as a co	insequence of):	u re	COV				1	TELL	
Due to (or as a consequence of):    Due to (or as a consequence of):			-	Sequentially list conditions,	Due to force a									
Due to (or as a consequence of):    Due to (or as a consequence of):		ted nsit	nine	cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	insequence or);								
See See See See See See See See See Se	<u>.</u>	execu n and ial-tra	Еха	triat iriniated events	Due to (or as a co	nsequence of):								
FFEMALE:   23b Was second pregnant   1   1   1   1   1   1   1   1   1	)9/	ysicie ysicie	cai		l									
25. Was case referred to medical examiner?	9	rtifica ng ph as th	Jedi	IE EENALE.										
25. Was case referred to medical examiner?	Š	ath ce tendii or use	an/h	23b. Was decedent pregnant 2			Ectopic prea	nancv					,	
25. Was case referred to medical examiner?		the al	sici	1 ☐ Yes 2 ☐ No	4 Pregnant at time						Month		Day Ye	ear
25. Was case referred to medical examiner?	σ.	that the	Ph		tributing to death but no	at resulting in the u	adarhina agu	na aiyaa ia	Dort	220 Did toba				
25. Was case referred to medical examiner?	ds,	signe d be	<b>9</b>	<b>3</b>	instang to double such	or resoluting in the th	idenying cau:	se given in	raiti,		-0			
25. Was case referred to medical examiner?	CO	w req beer shou	iete											
25. Was case referred to medical examiner?		he la e has age 2	mc							autopsy	prio	r to comp	pletion of cau	use of
The state of the s	ta		(D)					26	Piace of Dooth		KNo 1 🗆	Yes 2	□ No	
State   Stat		nysici nis cen direc			ospital:	2 ER/Outpatien	t 3 DOA	0.4			e 6 Other (	Specify)		
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29b. Signature and title of certifier  30. Name and address of serson who completed cause of death (Item 23a) (Type, Print)  31. Date filed (Month, Day, Year)  32. Registrar's Signature	0	ng Pt fter th		_	28a. Date of Injury (Month, Day Yea		28c.							
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29b. Signature and title of certifier  30. Name and address of serson who completed cause of death (Item 23a) (Type, Print)  31. Date filed (Month, Day, Year)  32. Registrar's Signature	sio	tendi leath. :or: A the fu	cati	2 Accident investigation					2 🗆 No					
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29b. Signature and title of certifier  30. Name and address of serson who completed cause of death (Item 23a) (Type, Print)  31. Date filed (Month, Day, Year)  32. Registrar's Signature	$\leq$	or At after of Direct in by	it i	determined	28e. Place of Injury - building, etc. (S)	At home, farm, stro oecify)	eet, factory, o	ffice	2	28f. Location (Stree City or Town, S	et and Number of State)	or Rural F	Route Numbe	∋ <i>r</i> ,
30. Name and address of feeson who completed cause of death (Item 23a) (Type, Print)  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature	_	spital lours nerai filled		29a. Certifier Certifying Phys	ician: To the best of m	knowledge dooth	Occurred of t	he time do	ate and place	and due to the	20/0) 0-7			
30. Name and address of feeson who completed cause of death (Item 23a) (Type, Print)  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature		19 Ho	dici	(Crieck Only 2 Medical Examin	At: On the basis of example	mination and/or inv	restigation, in	my opinion	n, death occurre	ed at the time, date	and place, and	due to th	ed. ne cause(s)	
30. Name and address of feeson who completed cause of death (Item 23a) (Type, Print)  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature		To th Withir To th comp	×	29b. Signature and title of certifier	24		29c. L	icense num	nber	29d.	Date signed (A	fonth, Da	ay, Year)	
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature 405 April 12 42	)			1/1/1	0		1	12	5800	5 1	2:/2	1:	200	<u></u>
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	,			30. Name and address of borson who oo	hpleted cause of death	(Item 23a) (Type,	Print)		1	6/1	1	1	3	2
Ciate	5			1711acl 1 18	NS 74	10001	MOL	7/	ne 1	YESON	Our /	100	5/2	42
			9		4	eignature A. A.	ented							

				artment of Health and Me ertificate of Death	ental Hygien Reg. No	. 000	16297
	Physici		1. Decedent's Name (First, Middle, Last)  Mildred E. Current		2. Date of Death Month Da	ZOOS	3. Time of Death 1:40P M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	40	. County of Death	
		Ĭ.	Suburban Hospital	Bethesda		Montgome	ery
	Funeral Director		5. Social Security Number 3 0 0 − 1 8 − 1 0 0 9 6. Sex 1 □ M 2 1 1 F 8 3 Yrs.	) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Year) June 21,	9. Birthp Coun 1921 Ohi	ace (State or Foreign try) . O
	and w		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or t	ocation		11	Od. Inside City Limits
	Maryli f sho	tor	Md. Montgomery	Rockville			Yes 2 No
	with the sa or 28a- I be notifi	Direct	10e. Street and Number 9701-Veirs Drive	10f. Zip Code 20850	_	tizen of What Coun	try?
036	be filed within 72 hours after death with the Maryland tall Hygiene. id other than "natural", or Items 23a or 28a-f show odher than "natural", or Items 23a or 28a-f show event, the Medical Examinar must be notified at	by Funeral Director		Was Decedent of Hispanic Origin? (Specific Yes, specify Cuban, Mexican, Puerto Fi	city Yes or No- lican, etc.)	14. Race - Americ Black, White, 6 Specify: Whi	itc.
21215-0036	within 72 h ene. than "natu ha Medical	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation  s kind of work done during most of workin  DO NOT use retired)	g	Cind of Business/Ind	ustry
	Hygien Hygien thar th		12 17. Father's Name (First, Middle, Last)	Iomemaker	(First, Middle, Maider		
Maryland		To Be	E. Goddard		Provens	1 Jumamay	
	12 sho h and 7 la m traum			ing Address (Street and Number or Rural 0 - Michener Dr.			
Baltimore,	Pages 1 and nent of Healt int: If itam 2' iry or other	0.00	20a. Method of Disposition  **Disposition 3 Removal from State Forest I  **Onation 5 Other (Specify)  20b. Place of Disposition completely, or Forest I	osition (Name of paratory or other place) Lawn Cem. 5/2/20		ocation - City or To umbus , Oh	
Balt	permit. Pag Department Important: I any injury o once.		21. Signature of Funeral Serving Litensee	22. Name and Address of Facility Hysong Co., Inc.	6510-10 Washin	6th St., gton,DC	N₩
	Friysician /Medical Examiner		23a. Part1. Enter the disease, or commidations that daused the death. Do not enshock, or heart failure. List only one cause in each line.  Immediate Cause (Final disease or condition and the condition are utiling in death).	nonia (aspira Fi		none)	Approximate Interval Between Onset and Death
68760,	ificate be executed g physician and as the burial-transit	edical Examiner	resulting in death) Last Due to (or as a consequence of):	Houtel state	10		
.O. Box	The law requires that the death certificate has been signed by the attending tage 2 should be detached for use as	Physician/Me		□Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	y Day Year
Vital Records, P.	uires that signed b ld be deta	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		use contribute to the	a cause of death?
CO	aw requir is been si 2 should	Completed	Damontra.		24a. Was an	24b. Were autop	sy findings available
I Re	The la ate ha page 2	Com	Uninary Gract Infection		autopsy performed? 1 ☐ Yes 2 € No	death?	pletion of cause of 2 No
/ita	ician: Th certificate rector, pag	Be	25. Was case referred to medical	26. Place of Death			
of	Phys this al dii	10	1 ☐ Yes 2 ☐ 10 Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 2. Manner of Death 28a. Date of Injury 28b. Time		e 5 Residence		)
	ding I h. After funer	tlon	1 Matural 5 Pending (Month, Day Year) Injury	of 28c. Injury at Work?  M 1 ☐ Yes 2 ☐ No	od. Describe now inju	ry occurred	
Division	il or Attandi after death. Diractor: A I in by the fu	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	8f. Location (Street ar City or Town, State		Route Number,
	Hospital 24 hours Funaral stely filled	edical Ce	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, deal can be been consulted by the basis of examination and/or and manner stated.	th occurred at the time, date and place, an nvestigation, in my opinion, death occurred	nd due to the cause(s d at the time, date and	) and manner as sta d place, and due to	ated. the cause(s)
	To the Hos within 24 h To tha Fun completely	Me	29b. Signature and title/or certifier	29c. License number		te signed (Month, L	
				47867	4	127/05	5
	(5)		30. Name and 1 ress of care ompleted cause of death (Item 23a) (Type	·			
1			ONLY ZUNIGA 4701 – RANDO 31. Date filed (Month, Day, Year) 32. Registrar's Signature		LE,MD. 2	0852	
	Sta Registi		MAY 0 2 2005	nde			

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			_ For	•		d / Depa	artment of	Health and N	-	•	15 1000
			1 - Stete Registrer			Cei	rtificate o	Death		eg. No.	0 10290
	Physici	an	Decedent's Name (First, Middle,	Last)					2. Date of Dea Month	th Day Ye	
	/Medic		CONSTANCE			CULP			April	28, 200	
	Examir	ner	4a. Facility Name (If not institution,		ber)			or Location of Death		4c. County of D	
			Civista M 5. Social Security Number 6		Center '. Age (In yrs. Ia	et hirthday)	La If Under 1 Yea	Plata r   If Under 24 Hrs.	8 Date of Birth	Char	
	Funeral Director		217-42-1442	1 M 2 F	62	Yrs.	Months Day	s Hours Min.	8. Date of Birth (Month, Day)	Year) 9.	Birthplace (State or Foreign Country)
			Usual Residence of Decedent		02			Dec	elliber	22,1942	WV
	how how		10a. State 10b. County		10c. City,	, Town or Lo	cation				10d. Inside City Limits
	e Ma	cto	MD Charle	es	I	La Pl	ata				1 ☐ Yes 2 No
	or 28	Director	10e. Street and Number				10f. Zip Code		1	0g. Citizen of What	: Country?
	or death with the Maryland tams 23a or 28a-f ahow er must be mailified at	La La	10310 Charle				206			U.S.A.	
	e ta	Funeral	11. Marital Status	Armed Ford		5.   13. \	Was Decedent of f Yes, specify Cu	Hispanic Origin? (Sp ban, Mexican, Puerto	ecify Yes or No- Rican, etc.)		American Indian, Vhite, etc.
50	rs aff	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	d 1 □ Yes 2 If Yes, Give Year or Dai	X No		1 ☐ Yes 2X N	Specify:		Specify: T.T	That to a
2-003b	be filed within 72 hours after death w Ital Hygidhan "natural", or Itams 23a d other than "natural", or Itams 23a evant, tha Mwdical Examinat Innati		15. Decedent's		103.	16a, Dece	dent's Usual Occ	pation		16b. Kind of Busine	hite
	nin 72	plet	(Specify only highest Elementary/Secondary (0-12)	grade completed)	407.51)	(Give	kind of work don DO NOT use retii	e during most of work	ring		,
7	d with giene ar tha	Completed	Clementary/Secondary (0-12)	College (1	401 54)	5	Site Ma	nager		Oil Con	npany
and		Bec	17. Father's Name (First, Middle, La	st)				18. Mother's Nam	e (First, Middle, I	Maiden Sumame)	
		70 8	James Weldon	Rucker				Georgia			
a	2 should be and Mental is marked sumstic ev		19a. Informant's Name/Relationship					et and Number or Rur			e, Zip Code)
≥ ~``	s 1 and 2 should f Health and Mer itam 27 ia marke other traumatic		James Rucker/	ratner	ant Di-			St. Key			
0	Pages 1 ar nent of Hea int: If itam : iry or other		20a. Method of Dispesition 1 Derial 2 Cremation 3	☐Removal from S	tate Brir	metery, cren	sition (Name of natory or other pi LG-ECN	ace) s 04/3		20c. Location - City !harlott	e Hall, Md/
Dallimor	그 된 본 근		* 4 □ Donation 5 □ Other (Spe								
מ	permi Depa Impo any in		21. Signature of Funeral Service Lie	110	ر در (سام	Ar	ehart-	ress of Facility Echols F	uneral	Home, PA	
			23a. Part 1. Enter the disease, or or	emplications that ca	used the death.	Do not ent	• O • Bo:	x 567, L	a Plata	, Md. 20	6/16 Approximate
	al m		shock, or heart failure. List or Immediate Cause (Final	ly one cause on ea	ch line.		PSI.	-		,	Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a	r as a conseque		Lar.	۷	_		1
	Examiner				1 45 4 601150400	31.00 017.					
	e'	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury that initiated events	Due to (o	r as a conseque	ence of):					
	ate be executed nysician and he burial-transit	Examiner	Cause (Disease of injury that initiated events	c							
,00	e exe ian a urial-		resulting in death) Last	Due to (o	r as a conseque	ence of):					
-	ate b	dical		d							-
0 X O	ding p	/Me	IF FEMALE:	23c. If yes, outco	ome of pregnan	cv	100,700			and Date of a	de library.
	atten for us	lan	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live bir	th 2 Fetal o	death 3	Ectopic pregnan Other (specify)	су		23d. Date of o Month	Day Year
j .	w requires that the death certificat been signed by the attending phy should be detached for use as th	Physiclan/Med	1 □ Yes 2 □XNo 9 □ Unknown	9□ Unknov			(4,500.1)				
L	s that ned b e deta	by PI	Part II. Other significant condition	_		-	nderlying cause g	iven in Part I.	23e. Did tob	acco use contribute	to the cause of death?
cords,	quire an sig uld b	ed b	PIABE	ETES	-77	PE_	2		1 ☐ Ye	s 2 <b>X</b> No 3□	Probably 4 Unknown
2	aw re	Completed	HYPER	TENS	FON	•			24a. Was ar		autopsy findings available to completion of cause of
č	hysician: The law his certificate has b I director, page 2 si	mo;	CHRONEC			FA-	LUR	F.	perform	ed? death	
ום	stan: artifica ctor, I	BeC	25. Was case referred to medical examiner?	Har a resident		1		26. Place of Deat			
>	Physic this ce al dire	2	1 ☐ Yes 2 XNo	Hospital:	oatient 2 🗆 E	R/Outpatien		ther: 4 Nursing Ho	me 5 🗆 Reside	nce 6 □Other (S)	pecify)
=	ding P	on:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of (Month,	Injury 2 Day Year)	28b. Time of Injury		ork?	28d. Describe ho	w injury occurred	
<u>ה</u>	Attanding Pher death.	cat	2 Accident investigat 3 Suicide 6 Could not	he	f lains. At home	4		]Yes 2□No	20f Location /Str	and Alimbor or	Rural Route Number.
5	or Al after of Direction by	Certification;	4 Homicide determine		g, etc. (Specify)		eet, factory, office	•	City or Town		Hurai House (vuinber,
	spital		29a. Certifier 1 Certifying	Physician: To the b	est of my knowl	ledge, death	occurred at the	time, date and place,	and due to the ca	use(s) and manner	as stated.
:	To the Hospital or Attending Physician: The law requires that the death certifical within 24 hours after death.  To the Furnatal Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	edical	(Check only 2 Medical Ex	aminer: On the bas and manne	is of examination	on and/or inv	restigation, in my	opinion, death occurr	ed at the time, da	ite and place, and d	ue to the cause(s)
1	To the To the Comp	Me	29b. Signature and title of certifier		andl	of	29c. Licer	se number	29	d. Date signed (Mo	
			V, An	many			D-:	26064		04-2	8-2005
D	RC		30. Name and address of person wh	o completed cause	of death (Item 2	23a) (Type, I	Print)	don Dese	h Da CL		
4	00		Vidyasagar An		Jistrar's Signatu		α GOI	чен реас	ıı ku Uf	ar rotte	патт, пр
	Sta Registr		31. Date filed (Month, Day, Year)  MAY  0	2 2005	jişirar s Signatu Lüğlüğü	J.	Sparke				

			1 - For State Registrer	state of Maryland /		artment of H			jiene <sub>eg. Né.</sub> - ()	05	16299
	Physic	ian	Decedent's Name (First, Middle, Last)		-			2. Date of Dea Month	th Day	Year	3. Time of Death
	/Medi		Daniel Harvey Carl	augh				may	04	2005	1258 PM
1	Exami	ner	4a. Facility Name (If not institution, give stre			4b. City, Town, or		Death U		ty of Death	
_	Funeral		Washington County F  5. Social Security Number 6. Sex	7. Age (In yrs. last b	oirthday)	Hagers	If Under 24	Hrs. 8. Date of Birth		ingtor	
	Director		161-32-2750 <sup>1</sup> X <sup>M</sup>	-	Yrs.	Months Days	Hours	Hrs. 8. Date of Birth (Month, Day)  January 10	Year) 0.1940	PA	lace (State or Foreign try)
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. City, To		action		Don't Live To the Control of the Con	92210		
	Maryli f sho	ō								19	0d. Inside City Limits 1√2 Yes 2 ☐ No
	128a-	Director	MD Washingtor 10e. Street and Number	Ha	inco	10f. Zip Code		1	0g. Citizen of	What Coun	
	h with	a D	2 Fulton Street Ap	t. 2		21750		-	USA		,.
	ems (	Funeral		Was Decedent Ever in U.S. Armed Forces?	13. V		spanic Origin	? (Specify Yes or No- ruerto Rican, etc.)	14. Ra	ce - America	
36	s afte , or it	by Fu	1 Never Married 2 Married	1 ∐ Yes 2 DXNo If Yes, Give		Yes 2 No	Specify:	dono i modii, etc.)	Speci	ack, White, e	HC.
Ö	72 hours after death with the Maryland natural', or items 23a or 28a-1 show dical Examirer must be notified at	ed b	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Educat	Year or Dates:		ent's Usual Occupa				Whi	
215	within 72 ene. than "na	Completed	(Specify only highest grade of Elementary/Secondary (0-12)	mpleted)	(Give	kind of work done di DO NOT use retired)	uring most of	working	16b. Kind of E	dusiness/Ind	ustry
212	d with	mo:	9	College (1-4or 5+)	ller	Operator	r		Constr	uction	1
nd	be filed tal Hygi d other event, I	Be	17. Father's Name (First, Middle, Last)		Fe :			Name (First, Middle, M			
<u>y</u> a	should nd Men marka umatic	٩	Daniel Edward Car					ian Mae Ke			
Maryland 21215-0036			19a. Informant's Name/Relationship (Type,					r Rural Route Number,		, State, Zip	Code)
	s 1 and 2 Health tem 27 i		Patricia Snow/Daught 20a. Method of Disposition	20b. Place	of Dispos	Sition (Name of patory or other place	rive	Hancock, MD	21750 20c. Location	- City or Toy	wn. State
9	Pages nent of I ant: If its ary or o		1 X Burial 2 ☐ Cremation 3 ☐ Rem 14 ☐ Donation 5 ☐ Other (Specify)	JVai II OIII State							
Baltimore,	permit. I Departm Importal any Inju		21. Signature of Fineral S-Licensee	477		netery Name and Address		/07/05 Mx 141	cConne West N	IISDUr Main S	g, PA
<u>m</u>	Depa Impo any l		1 Line	Morn	Gr	ove Funer	cal Ho	me, P.A. Ha			
П			23a. Part1. Enter the disease, or complicat shock, or heart failure. List only one of	ons that caused the death. Do	not ente	r the mode of dying	, such as car	diac or respiratory arre	est,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Rectal	C	aneer					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence	of):						
		er	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence	of):						
V	uted d ansit	Examiner	cause. Enter Underlying		, .						
Ó	an an rial-tr	Еха	resulting in death) Last	Due to (or as a consequence	of):						
8760,	icate be executed physician and s the burial-transit	dlcal	d.								
9 ×	leath certific attending p	/Med	IF FEMALE:						1		
Box	attene for us	sian	in the past 12 months?	f yes, outcome of pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death		Ectopic pregnancy				ite of deliver	y Day Year
P.O.	the d ay the	ysic		9 Unknown	3 🗆	Other (specify)					
ď.	The law requires that the death certific tte has been signed by the attending p vage 2 should be detached for use as	by Physician/Med	Part II. Other significant conditions contrib		in the un		n in Part I.	23e. Did tob	acco use con	tribute to the	cause of death?
ž	aquire en sig ould b	ed b	Metasta	sis to	h U.	ng of	L'IV	<u>₹</u> 1 □ Ye	s 2 🗆 No	3 Proba	bly 4 Donknown
Vital Records,	has be	Completed						24a. Was an		Were autops	sy findings available
		Con						perform	ed?	death? 1 🗌 Yes 2	pletion of cause of □ No
Vita	ician: Sertific ector,	Be	25. Was case referred to medical examiner?	A-1.				Death (Check only one	)		
ō	Phys	- T	1 ☐ Yes 2 ☐ No Hosp 27. Manner of Death 2	1 Lupratient 2 LER/O	utpatient Time of		4	g Home 5 Resider			
0	th. : After	tlon	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		Injury	28c. Injury a Work? M 1 □ Ye	as 2 □ No	28d. Describe how	w injury occur	red	
Division of	Atter or dea actor by the	ifica	2 Could not be	Be. Place of Injury - At home, fa	arm, stre			28f. Location (Str	eet and Numb	er or Rural i	Route Number,
	tal or	Certification:	4   Nomicide	building, etc. (Specify)				City or Town,	State)		
	or the Hospital or Attending Physician: within 24 hours after death. To the Funeral Diractor: After this certifical completely filled in by the funeral director,			n: To the best of my knowledge On the basis of examination ar	e, death	occurred at the time	, date and pl	ace, and due to the car	use(s) and ma	anner as stat	ted.
	the the mplet	Medical		and manner stated.							
	F 3 7 8	-	29b. Signature and title of certifier	when		29c. License		396	d. Date signer		
	,	-	30. Name and address of person who compl	ated cause of death (from 225)	(Type P	riot) 112C	00	al cour	6 J	7 10)	
	6		FARID MUR	- SHED	(туре, Р	1-1 ~	10 2 x < 1	town ,	(1)	2176	10
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature			<u> </u>				, ,
h,	Registra	ar	MAY 1 3 20	15 Mary B	3 /	and I					

			1 - For State Registrar	State	of Maryla		artment of H			giene Reg. No.	005	16300
			Decedent's Name (First, Middle, La	st)					2. Date of Dea	ath		3. Time of Death
	Physici /Medic		Marie	S		eSantis			April 28,	2005	Year	10:55 Р м
	Examin		4a. Facility Name (If not institution, give				4b. City, Town, or	Location of Dea	th	4c. Co	unty of Deat	h
			Bradford Oaks Nursin				Clint	On If Under 24 Hrs			ce Geor	
	Funeral Director		055-05-3219	sex 1 □ M XXXXF	7. Age (In yrs	s. last birthday) Yrs.	If Under 1 Year Months Days	Hours Min		y, Yeer)	NT CC	hplace (State or Foreign YORK
	and		Usual Residence of Decedent  10a. State 10b. County		10c. C	City, Town or Lo	cation					10d. Inside City Limits
	Maryl f ehc	ļo	Maryland Prince Geo	raota		Comp Com	inaa					1 ☐ Yes 2XX No
	r 28e	Director	10e. Street and Number	ige s		Camp Spr	10f. Zip Code			10g. Citizen	of What Co	ountry?
	h with		8601 Temple Hills Ro	ad			20748				USA	
	deat	Funeral	11. Marital Status		cedent Ever in	U.S. 13.	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (S	Specify Yes or No-		_ :	rican Indian,
36	should be filed within 72 hours after death with the Maryland nd Mental Hygiene. marked other than "natural", or Iteme 23s or 28e-f show imelic event, I'm Medical Everal ast Le rediffed at	by Fu	1 ☐ Never Married 2 € Married 3 ☐ Widowed 4 ☐ Divorced		2XXNo	j	1 ☐ Yes 2XXX No	Specify:	to the state of th			White
ð	2 hou	ted	15. Decedent's E	ducation		16a. Dece	dent's Usual Occupa	ition	1	16b. Kind	of Business/	Industry
21215-0036	ithin 7 ne. nan "n	Completed	(Specify only highest grant Elementary/Secondary (0-12)		(1-4or 5+)	life.	kind of work done d DO NOT use retired	(uring most of wo	rking	Cloth	ino	
	ould be filed with Mental Hygiene. arked other than etic event, I'm		8th 17. Father's Name (First, Middle, Last	)	-	Se	amstress	18 Mother's Na	me (First, Middle,			
ano	d be f antal I red of	To Be	Thomas Punzina	,					Basile	maidon Sui	mamo,	
Maryland	es 1 and 2 should b of Health and Ment: I item 27 is marked r other traumetic e	Ĕ	19a. Informant's Name/Relationship (	Type, Print)		19b. Mailir	ng Address (Street a			r, City or To	wn, State, 2	Zip Code)
	and 2 ealth a n 27 is		Ferdinand S. DeSantis	/ Husbar	nd	8601	Temple Hill	s Road Can	m Springs.	Maryl	and 207	4×
ore,	es 1 a of He fitem		20a. Method of Disposition 1. Surial 2 □ Cremation 3 □		20b.	Place of Dispo	sition (Name of natory or other place		Date	20c. Locat	ion - City or	Town, State
Ĕ	Pages ment of ant: If it		'4 □ Donation 5 □ Other (Specia		Res		n Cemetery	-			, Maryl	
Baltimore,	permit. Pages Department of I Important: If it any injury or o		21. Signature of Funeral Septice Lice	05.96 J			. Name and Addres					ome P.A. 745
			23a. Part1. Enter the disease, or com	plications that	caused the dea	I				-	.nu 20	Approximate
	Dhuminian		shock, or heart failure. List only Immediate Cause (Final	one cause on	each line.	11	1	~ ;				Interval Between Onset and Death
	Physician / /Medical		disease or condition resulting in death)	a	(or as a conse		mer	D/15N-	75			yours
	Examiner		Conversion to the secondarions	b								
	p ti	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to	o (or as a conse	equence of):						
	ecute and i-trans	Examine	that initiated events resulting in death) Last	c	o (or as a conse	adheuce ot).						
8760,	cate be executed physician and the burial-transit	aiE		-d	, , , , , , , , , , , , , , , , , , , ,	.,						
68/		edicai		d								
Box	death certifii e attending p id for use as	M/u	IF FEMALE: 23b. Was decedent pregnant		utcome of pregr		Ectopic pregnancy			23d.	Date of del	
О		Physician/M	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		nant at time of		Other (specify)				Month	Day Year
٦.	that the edby the detacher		Part II. Other significant conditions	contributing to	death but not re	esulting in the u	nderlying cause give	on in Part I	23e. Did to	bacco use	contribute to	the cause of death?
ecords,	The law requires that ite has been signed b page 2 should be deta	d by				, , , , , , , , , , , , , , , , , , ,	isony nig dagge gire					obabiy 4 XXInknown
Ö	s beer s shou	ompieted			_				24a. Was a	an 2	4b. Were au	topsy findings available
$\mathbf{r}$	sician: The lav certificate has irector, page 2								autop perfor	med?	death?	completion of cause of
Vital	stan: ertifica ctor, p	BeC	25. Was case referred to medical examiner?					26. Place of De	ath (Check only or			
o S	Physician: this certific al director,	P	1 ☐ Yes 2 <b>XX</b> No			☐ ER/Outpatien		4 K Nursing r	Home 5 Resid			cify)
		ertification;	27. Manner of Death 1 XXXX tural 5 ☐ Pending		of Injury nth, Day Year)	28b. Time of Injury	Work	at :? /es 2 □ No	28d. Describe h	ow injury of	curred	
Division	death death ctor: / the	ficat	2 Accident investigatio 3 Suicide 6 Could not be determined	00 Olas	e of Injury - At	home, farm, str	eet, factory, office		28f. Location (S	treet and N	umber or Ru	ral Route Number,
2	in Sir e	Certi	4 Homicide	build	ding, etc. (Spec	cify)	,		City or Tow			
	0 4 5 8	edical (		miner: On the			occurred at the time vestigation, in my op					
	To the h within 24 To the F	Me	29b. Signature and title of certification				29c License	number (42)	2	29d. Date si	gned (Month	n, Day, Year)
)	(2)		30. Name and address of person who	completed car	ise of death (the	am 23a) /Tuno	Print)	73/		4 -1	101	
_	(3)		Frank the R	you	11701	LIVING	1/200/4	14/05 1	7. NA	myt	NK	W 20744
	Sta		31. Date filed (Month, Day, Year)	- 1	Registrar's Sign	nature				1		
Di	Registr	ar	MAY 0 2 200	Die	in A	Spe						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 6:33 AM Apr. 28, 2005 Nina Dobbs /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 8101- Connecticut Ave. Chevy Chase Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Months Days Hours Min. (Month, Day, Year)
May 16,1912 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign Country)
Illinois **Funeral** 1 □ M 2 🛛 F 057-01-0151 Director 92 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits "natural", or items 23a or 28a-f shov adical Examiner must be notified at Md. Montgomery Chevy Chase Director 1 Nos 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be flied within 72 hours after death with intent of Health and Mental Hygiene.
ant: if item 27 is marked other than "natural", or items 23a or items or or other traumatic event, it a Medical Examination in the intent must be in 8101- Connecticut Ave. #709 20815 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker At Home 12 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) Leo Peterson Sonia Zaret ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dr.Leland Dobbs- Son 6150- Estates Dr., Oakland, Cal. 94611 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Department of important: if any injury or once. Metropolitan Crematory 4/30/05 Alexandria, Va. <sup>¹</sup> 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility 6510-16th St., NW Hysong Co., Inc. Washington, DC was in that leaved the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and each line. 23a. Part1. Enter the disease, or complications shock, or heart failure. List only one caus Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician Colon Cancer resulting in death) /Medical Due to (or as a consequence of): Examiner Atrial Fibrilation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or Injury that in ideal awants Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi attending physician and resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Day 4☐Pregnant at time of death P.O. 5 ☐ Other (specify) ed by the a detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \( \) Nursing Home \( 5 \) Residence \( 6 \) Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification; To 1 ☐ Yes 2 XNo this After thi funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 🗀 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 Suicide in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) nin 24 hours after the Funeral Direct 4 Homicide 29a. Certifier | Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 2 29c. License number 29d. Date signed (Month, Day, Year) dunin mas Malan 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Susan Scanlon- 5530- Wisconsin Ave. 31. Date filed (Month, Day, Year) State Registrar

		1 - For State Registrar	State of Ma	aryland / Depa <i>Cel</i>	artment of H <i>rtificate of L</i>		lental Hygier Reg. R		
	sician edical	I harles Edwar		rger, Sr.			2. Date of Death Month April 2	7 2005	3. Time of Death 6:30 A M
	miner ral	4a. Facility Name (If not institution, 18652 Carolyn	St.	e (In yrs. last birthday) Yrs.		rstown If Under 24 Hrs. Hours Min.	8. Dete of Birth (Month, Day, Yea Feb. 13, 19	9. Birth	ington hplace (State or Foreign untry) Yand
ס		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	ocation	1	1 60.15,19	40   1181	10d. Inside City Limits
the Mary	Director	Maryland Washi	ngton	Н	agerstown	ı	100 (	Citizen of What Co	1 ☐ Yes 2 No
72 hours after death with the Maryland neturel', or Items 23a or 28a-1 show that the market and	Funeral Dir		12. Was Decedent	Ever in U.S. 13.	2	1742 Ispanic Origin? (Spe n, Mexican, Puerto		USA 14. Race - Ame	
OSO ours after o	by Fun	3 ☐ Widowed 4 ☐ Divorced	Armed Forces?	No	If Yes, specify Cuba 1 ☐ Yes 🛣 No	n, Mexican, Puerto Specify:	Rican, etc.)	Black, White	White
III A I A IS - UOSO  be filed within 72 hours after death with the Marylan hat Hygiene.  coftoner then "neturel", or thems 23a or 28a-f show awant the western France.	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4or 5	ife.	DO NOT use retired	,	ng 16b.	Kind of Business/I	,
be filed water the definition of the files	B C C	17. Father's Name (First, Middle, L.	,		Carpenter	18. Mother's Name	(First, Middle, Maide Elizabeth		ction
Gore, Marylar ges 1 and 2 should be it of Health and Menta if item 27 is marked	1	19a. Informant's Name/Relationshi		19b. Mailir		and Number or Rura	l Route Number, City	or Town, State, 2	
iges 1 and 3 to 1 Health it of Health 27 or other tr		Shirley L. Eich 20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation	3 □Removal from State	20b. Place of Dispo cemetery, crei	matory`or other plac	e)   C		Location - City or	Town, State
DallIIIIO permit. Pages Department of Important: If it	ouce.	'4 □ Donation 5 □ Other (Sp.	conseq	_ 8	SBOTTE TU	inefally Hom	ne, P.A.	200 -0 100	n,Maryland
Physici	an	23a. Part 1. Fifer the disease, or conditions the condition of the condition resulting in death)	omplications that caused nly one cause on each lie		er the mode of dying	g, such as cardiac o	r respiratory arrest,	llamspor	Approximate Interval Between Onset and Death
/Medic Examin	er		bC	a consequence of):	is	liner			yeus
ficate be executed physician and sthe burial transit	al Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.	a consequence of):					
The Colius, F.C. DOX 00 fou,  The law requires that the death certificate be executed tite has been signed by the attending physician and made 2 should be deached for use as the burial-transit	hvslclan/Medical		d.  23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)			23d. Date of deli-	very Day Year
w requires that been signed by should be detailed.	d by P	Part II. Other significant condition	s contributing to death b	ut not resulting in the u	nderlying cause give	en in Part I.			the cause of death?
	amo						24a. Was an autopsy performed?	prior to c death?	topsy findings available completion of cause of
this aldi	tlon: To Be	25. Was case referred to medical examiner?  1 □ Yes 2 No	28a. Date of Inju (Month, Da)	int 2 ER/Outpatier ry 28b. Time of Injury	f 28c. Injury Work	at Nursing Hor	(Check only one)  ne 5 X esidence 28d. Describe how in		ify)
To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the tuneral	Certification:		ot be One Bloom of Init	ury - At home, farm, str c. (Specify)			28f. Location (Street : City or Town, Sta	and Number or Ru te)	ral Route Number,
the Hospit. in 24 hours he Funere	edical C	29a. Certifying (Check only one)	Physicien: To the best xeminer: On the basis of and manner sta	examination and/or in	n occurred at the fim vestigation, in my op	ne, date and place, a pinion, death occurre	and due to the cause( ad at the time, date a	s) and manner as nd place, and due	stated. to the cause(s)
To t To t	2	29b. Signature and the of certifier	7.	thee	29c. License	1000		Pate signed (Month	
6H-4		GUKIT 1	To cerhpleted cause of d	A 36	G Mil	lst.	Hageis	.tron a	DA149
Reg	State jistrar	31. Date filed (Month, Day, Year)	2005 32. Registra	ar's Signature	reile		·		

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ORIGINAL

	1	State Unpend Item	State of Ma 23a&27 per	arylan me	id / Depa G843 Cei	artme tifica	nt of H	ealth a Seath	and M	fental I	Hygien Reg. N	e () (	05	163	03
Physician		. Decedent's Name (First, Middle, L	ast)							2. Date of Month		ay	Year	3. Time of E	Death
/Medical	1	Jody L. Feather								May 8	, 200	05	1941	9:08 A	4 M
Examiner		a. Facility Name (If not institution, gi	,			4b. City	, Town, or	Location of	of Death		4	c. County	of Death		
		29428 Sullivan I				Traj		,			Ta	albot			
Funeral Director		i. Social Security Number 6. 410-29-5428  Usual Residence of Decedent	Sex 7. Ag 1. Mg 2 □ F	e (In yrs. 41	last birthday) Yrs.	If Unde Months	Days	If Under Hours		8. Date of (Month) April	19,1	964	Cou	place (State or ntry) yland	Foreig
and	$\vdash$	0a. State 10b. County		10c. Cit	y, Town or Lo	cation								10d. Inside City	/ Limit
tha Marylan 28a-f show notified at	ō	Micomi	<b>CO</b>	Sal	lisbury	7								1 X Yes	
with the Mar		laryland WICOIIII Oe. Street and Number	CO	- Da.	LIDOGL		ip Code				10g C	itizen of	What Cou	ntry?	
38 o	5 = ac	6 Unland Court					1801				US			,	
deati	1	1. Marital Status	12. Was Decedent Armed Forces?	Ever in U.	S. 13. V	Vas Dece	edent of Hi	spanic Orig	gin? (Spe	ecify Yes or	No-		e - Americ	can Indian,	
BAITIMORE, IMARYIGANG 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other then "neturel", or items 23e or 28e-1 show spiny or other traumatic event, I'th Medical Examinat must be notified at once.  To Be Completed by Funeral Director	Dy ru	06 Upland Court  1. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced	1 Yes 2 1 1 Yes 2 1 1 Yes, Give Year or Dates:	No	ł	_	ecify Cuba 2 <b>]</b> No	n, Mexican Specify:	n, Pu <i>er</i> to	Rican, etc.)			ck, White, v: Whi		
2 hours		15. Decedent's 8	ducation		16a. Deced	lent's Usi	ual Occupa	ıtion			16b.	Kind of B	usiness/In	dustry	
Maryland 21215-0036 td 2 should be filed within 72 hours aft th and Mental Hygiene. 27 is marked other then "neturel", or traumatic event, the Medical Exprin To Be Completed by F	Jupie	(Specify only highest gi	ade completed) College (1-4or 5	5+)	(Give life. L Chef	DO NOT I	ork done d use retired,	luring most	t of worki	ing		ood		,	
Hygi Hygi But, ant, and		7. Father's Name (First, Middle, Las	")		00			18. Mothe	r's Name	(First, Mia			ne)		
yland hould ba fi Mental H narked ott natic ever	2	Frank K. Feather						Shir	ley	Dye					
Mal		19a. Informant's Name/Relationship								il Route Nu				Code)	
Ce, L	-	Jennifer Scott/C	augnter	20b B	606 to			urt S		bury,					
Saltimore, bemit. Pages 1 ar bepartment of Hea mportant: if item: my injury or othermore.	2	1 ☐ Burial 2 ☐ Cremation 3 [		a	emetery, crem Lisbury	natory or	other place			Date L3, 20			•	own, State	
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Demi Depa Impo eny ii	5	Javis 24. Com	poson C	FSF	)									socitai	on
		23a. Part1. Enter the disease, or con shock, or heart failure. List only	pications that caused	the death	n. Do not ente	or the mo	de of dying	, such as	cardiac o	alisb or respirator	y arrest,	ב עויו	.1004	Approximate	
Fnysician		mmediate Cause (Final			1 D.									Interval Betwee Onset and De	
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Examiner		Samuel Market and Parameter an	b												
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ficate be executed ficate be executed physician and s the burial-transit edical Examiner	t	nat initiated events	c												
B exe	֓֞֜֜֜֜֜֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓	esulting in death) Last	Due to (or as	a consequ	ience of):										
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ng pt ng pt s as th		F FEMALE:				- 381									
nat the death certifing d by the attending letached for use as Physician/Me	2	3b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth	of pregna	ncy death 3□	Ectonic n	regnancy						e of delive	ery	
that the death end by the atterded for detached for Physicia	2	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at 9□Unknown			Other (s					- 1	Moi	nth	Day Yea	ar
nat the d d by the letached		9 🗌 Unknown					-								
	ב ב	art II. Other significant conditions	contributing to death be	ut not resu	ulting in the un	derlying	cause give	n in Part I.			d tobacco □ Yes 2			ne cause of dea ably 4 Quni	
aw requ	5									24a. W		24b. V	Vere autor	psy findings ava	ailabl
sicien: The law requires t sicien: The law requires t certificate has been signe irector, page 2 should be e.		5. Was case referred to medical	65							pe	topsy rformed? s 2 \( \) No	, p	rior to cor leath?	npletion of caus 2□ No	se of
ysicien ysicien s certifi director		examiner?  1 X Yes 2 No	Hospital:	- 00			Otho			Check on					
Phys arthis aral dis	-	7. Manner of Death	28a. Date of Injur (Month, Day		ER/Outpatient 28b. Time of		28c. Injury	4 🗆 1401	-	ne 5∟Re 28d. Describ				scene	_
ding th. After funer funer		1 Natural 5 ☐ Pending 2 ☐ Accident investigation		Year)	Injury	м	Work'	? es 2.⊟N				.,			
train or Attending Physicien: state death el Director After this certification by the funeral director, recrtification; To Be C		3 ☐ Suicide 6 ☐ Could not b	e Zen Plans of Iniv	ry - At ho	me, farm, stre	et, factor				8f. Location	(Street a	nd Numbe	er or Rura	l Route Number	r.
= 58.5 E	5	4  Homicide determined	building, etc	. (Specify	)	,	,,			City or	own, State	9)			
fosp t hou une sly fil		9a. Certifier (Check only one)  1 Certifying Pi 2 Medical Example	nysician: To the best of niner: On the basis of and manner sta	examinat:	wledge, death ion and/or inv	occurred estigation	at the time	e, date and nion, death	d place, a	nd due to the	ne cause(s e, date an	and mai	nner as sta	ated. the cause(s)	
To the H within 24 To the F complete		9b. Signature and title of certifier	and manner sta			29	c. License	number			29d Da	te signed	(Month !	Day, Year)	
⊢ 3 ⊢ ŏ		· auetz					OCM					9, 2		,,)	
	3	0. Name and address of person who		eath (Item	23a) (Type, F	rint)	Penn	Stree	7† E	Raltim				21201	
	2	1. Date filed (Month, Day, Year)		ele Clear			CIIII	PETEE	- L	MAL L LII	ore,	rary	TallQ	Z1ZUI	
State Registrar	16	MAY 1 1	2005 32. Refistra	u o oignat	B A	hack									

State of Maryland / Department of Health and Mental Hygiene [] [] 5 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** Month. Year Samuel Martin FOLTZ 09 2005 Mpru /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Washington County Hospital Hagerstown Washington 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days Hours 1⊠M 2□F 60 220-42-5908 Yrs. Director June 29, Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits items of the marked other than "neturel" or Items 23e or 28a-f show other treumstic event, It a Medical Examiner must be notified at 1 TXYes 2 ∏No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 852 W. Irvin Avenue 21742 USA death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 is marked other then "neturel", or Itel Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: WHITE Baltimore, Maryland 21215-0036 þ 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) parts manager equipment 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Samuel Morin Foltz Connie L. Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 304 Belview Avenue, Hagerstown, Maryland 21742 Jeff Foltz - son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or o 1 Burial 2 □ Cremation 3 □ Removal from State ` 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery 4-29-05 Hagerstown, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility MINNICH FUNERAL HOME estal 415 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Athorose disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner ed by the attending physician and detached for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): THX TO UK THE PELME Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2 \( \text{No} 1 ☐ Yes 2 X No 1 TYes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural Injury 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 04-26-2009 30. Name and address of person who completed cause death (Item 23a) (Type, Print) 31. Date filod (Month, Day, Year) 32. Registrar's Signature State Registra

	_	Trogram and the state of the st	rtment of Health and M tificate of Death		Reg. No. 2005   630
Physicia /Medica Examine	ai -	1. Decedent's Name (First, Middle, Last) ALICE T. GUILBERT  4a. Facility Name (If not institution, give street and number) Ft. Washington Hospital	4b. City, Town, or Location of Death Ft. Washington	2. Date of Dea Month April	Day Year 3. Time of Death 7:46 P M 4c. County of Death Prince George
Funeral Director		$ \begin{array}{c ccccccccccccccccccccccccccccccccccc$	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birt (Month, Da) 02/16/1	h 9. Birthplace (State or Foreign Country)
1215-0036 within 72 hours after death with the Maryland ane. then "naturat", or Items 23e or 28e-f show the Medical Examiner must be notified at	Director	MD Prince George Upper Mar 1  10e. Street and Number	boro 10f. Zip Code		10d. Inside City Limits  1√√√√√√ Yes 2 □ No  10g. Citizen of What Country?
136 rs after death w t', or items 23a	Completed by Funeral Director	1 Never Married 2 Married 1 Yes 2 No	20744  Vas Decedent of Hispanic Origin? (Sp. Yes, specify Cuban, Mexican, Puerto  ☐ Yes 2 No Specify:	ecify Yes or No- Rican, etc.)	USA  14. Race - American Indian, Black, White, etc.  Specify: Black
21215-0036 ad within 72 hours aft giene. or then "natural", or it the Medical Exerci-	completed	15. Decedent's Education 16a. Deced	ent's Usual Occupation kind of work done during most of work O NOT use retired) Care	ing	16b. Kind of Business/Industry  Private
Maryland 2 Id 2 should be filed Ith and Mental Hygi 77 Is marked other treumatic event, I	Be	17. Father's Name (First, Middle, Last)  John Butler  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing	18. Mother's Name  Cathering  Address (Street and Number or Rura	ne Savoy	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mantal Hygiene. Importent: If item 27 is marked other then "naturat", or items 23s or 28a-f show any njury or other treumatic event, the Medical Exercites must be notified at ones.		20a. Method of Disposition  1 Disposition  2 Cremation 3 Removal from State  2 Other (Specify)  20b. Place of Disposition Cemetery, cremit Resurrection	actory or other place) 1 Cemetery 05/01/	2005	20c. Location - City or Town, State Clinton, MD
Balt permit. Depart Import any inji			Name and Address of Facility Cerl 11 Fennsulvania Ave.	Suitland,	MD 20746
76( ysicie	icai Examiner	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C.  Due to (or as a consequence of):  Due to (or as a consequence of):	DI SORAFR TIC CERFORD VA	SCULA	Interval Between Onset and Death HOURS  HEARS
P.O. Box 68 nat the death certifica d by the attending ph etached for use as th	Physician/Med		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
S, es the est	by	Part II. Other significant conditions contributing to death but not resulting in the unit ROULC DESTRUCTIVE LUNG	derlying cause given in Part I.	X	obacco use contribute to the cause of death?  Yes 2 No 3 Probably 4 Unknown
<u>a</u> a	e Completed	25. Was case referred to medical	26. Place of Deat		prior to completion of cause of death? 2D No 1  Yes 2 No
on of ding Phys	To B	examiner?  1 Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient  27. Manger of Deal 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation  28a. ate of Injury 28b. Time of Injury	Other: 4 Nursing Ho	me 5 Resid	dence 6 Other (Specify) now injury occurred
	ai Certification;	3 Suicide 4 Homicide  6 Could not be determined  28e. Place of Injury - At home, farm, streen building, etc. (Specify)  29a. Certifier  1 Certifying Physician: To the best of my knowledge, death		City or Tox	
To the Hos within 24 h	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and/or invalid and manner stated.  29b. Signature and title of certifier		ed at the time,	
Stat Registra		30. Name and addre of per on o completed cause of death (Item 23a) (Type, F Louis Kaurfman, M.D. 12070 Old Line Completed cause of death (Item 23a) (Type, F Louis Kaurfman, M.D. 12070 Old Line Completed cause of death (Item 23a) (Type, F Louis Kaurfman, M.D. 12070 Old Line Completed cause of death (Item 23a) (Type, F Louis Kaurfman, M.D. 12070 Old Line Completed cause of death (Item 23a) (Type, F Louis Kaurfman, M.D. 12070 Old Line Completed cause of death (Item 23a) (Type, F Louis Kaurfman, M.D. 12070 Old Line Completed cause of death (Item 23a) (Type, F Louis Kaurfman, M.D. 12070 Old Line Completed cause of death (Item 23a) (Type, F Louis Kaurfman, M.D. 12070 Old Line Completed cause of death (Item 23a) (Type, F Louis Kaurfman, M.D. 12070 Old Line Completed cause of death (Item 23a) (Type, F Louis Kaurfman, M.D. 12070 Old Line Completed cause of death (Item 23a) (Type, F Louis Kaurfman, M.D. 12070 Old Line Completed cause of death (Item 23a) (Type, F Louis Kaurfman, M.D. 12070 Old Line Completed cause of death (Item 23a) (Type, F Louis Kaurfman, M.D. 12070 Old Line Completed cause of death (Item 23a) (Type, F Louis Kaurfman, M.D. 12070 Old Line Completed cause of death (Item 23a) (Type, F Louis Kaurfman, M.D. 12070 Old Line Completed cause of death (Item 23a) (Type, F Louis Kaurfman, M.D. 12070 Old Line Completed cause of death (Item 23a) (Type, F Louis Kaurfman, M.D. 12070 Old Line Completed cause of death (Item 23a) (Type, F Louis Kaurfman, M.D. 12070 Old Line Completed cause of death (Item 23a) (Type, F Louis Kaurfman, M.D. 12070 Old Line Completed cause of death (Item 23a) (Type, F Louis Kaurfman, M.D. 12070 Old Line Completed cause of death (Item 23a) (Type, F Louis Kaurfman, M.D. 12070 Old Line Completed cause of death (Item 23a) (Type, F Louis Kaurfman, M.D. 12070 Old Line Completed cause of death (Item 23a) (Type, F Louis Kaurfman, M.D. 12070 Old Line Completed cause of death (Item 23a) (Type, F Louis Kaurfman, M.D. 12070 Old Line Completed cause of death (Item 23a) (Type, F Louis Kaurfman, M.D. 12070	enter, Waldorf, M	20602	

State of Maryland / Department of Health and Mental Hygiene [] [] [5] Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 2005 May 6, 5:35 P. Green Rebecca Grace /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Frederick Northampton Manor Health Care Center Frederick | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | March 14, 1922 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 □ F 83 215-14-2490 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County or than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2 → No Frederick Frederick Directo Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21702 U.S.A. 8616 Yellow Springs Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Y Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify Specify: White Baltimore, Maryland 21215-0036 þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry : 15. Decedent's Education permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiens. Important: If Item 27 is marked other than 'na any injury or other traumatic event, The Madic 2006. (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 8 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Lillie Harris William Moss 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1471 Eden Road, Frederick, Maryland 21701 Susan R. Anderson/Daughter Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of 1 Burial 2 Cremation 3 Removal from State Mt. Olivet Cemetery May 11, 2005 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign ture of Funeral Service Licensee 22. Name and Address of Facility
Keeney and Basford Funeral Home M00021 xullard 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Destrutive lung decease Immediate Cause (Final Chronic **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** 0) The Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 ☐ Pregnant at time of death 5 Other (specify) cate has been signed by the a page 2 should be detached to 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Vascular disease Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed 1 ☐ Yes 2 No certificate 26. Place of Death (Check only one) funeral director, 25. Was case referred to medical examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☐ No Certification: To 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manper of Death 28a. Date of Injury (Month, Day Year) After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No n 24 hours after death.

Se Funeral Director: A sletely filled in by the fi death. 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State MAY 1 3 2005 Registrar

			State of Maryland / Dep		lental Hygie	
	Physici /Medic Examir	al	Decedent's Name (First, Middle, Last)     WINIFRED IVIDENE HAHN  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	2. Date of Death Month FEBRUARY	Day Year 3 2005 18:05 M 4c. County of Death
	Funeral Director		MEMORIAL HOSPITAL  5. Social Security Number 6. Sex 1 M 2 M F 74  Yrs.  Usual Residence of Decedent	CUMBERLAND  If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, You MAY 30, 1	ALLEGANY  93. Birthplace (State or Foreign Country)  MARYLAND
36	permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: if item 27 is marked other then "neturel", or items 23a or 28a-f show any injury or other traumatic event, it a Modical Examiner must be notified at Once.	y Funeral Director	10a. State			10d. Inside City Limits 1 □ Yes ※□ No  Citizen of What Country?  U•S•A•  14. Race - American Indian, Black, White, etc.  Specify: NULTURE
Maryland 21215-0036	be filled within 72 hours ital Hygiene. Id other then "neturel! event, It e Madical Ex	Be Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	ident's Usual Occupation kind of work done during most of worki DO NOT use retired)  VNER  18. Mother's Name	ng 16l	b. Kind of Business/Industry  GROCERY STORE
d)	les 1 and 2 should be of Health and Mental fitem 27 is marked to other traumatic ever other traumatic ever	ToB	CHERYL VonHAGEL / DAUGHTER P. C	SARAH Ving Address (Street and Number or Rura  D. BOX 470 — FORT A position (Name of matory or other place)	ASHBY, WV	
Baltimore,	permit. Pages: Department of H Importent: If ite any injury or ot		21. Signature of Funeral Service Unense	IBY CEMETERY 02/06, UPCHURCH FUNERAL F P.O. BOX 1260, FOI	HOME, INC	พพ 26710
760,	Medical Examiner  /Medical phase and phase and phase and phase and phase and phase are also also and phase are also are also also are also and phase are also are also and phase are also also are also are also also are also also also also also also also also	lical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):		r respiratory arrest,	Approximate Interval Bastween Onset and Death TINKNOWN
.O. Box 68	res that the death certifica igned by the attending ph be detached for use as th	Physician/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
Records, P	The law requi ate has been s page 2 should	Completed by	Part II. Other significant conditions contributing to death but not resulting in the DECURRENT UROSEPSIS		1 Yes  24a. Was an autopsy performed 1 Yes 2	2 No 3 Probably 4 Unknown  24b. Were autopsy findings available prior to completion of cause of death?  17 Yes 2 No
Division of Vital	Attending Physicien: The Ir death. ector: After this certificate ha ector: After this certificate ha	Certification; To Be	25. Was case referred to medical examiner?  1	of 28c. Injury at Work?  M 1 \sum Yes 2 \sum No	ne 5 ☐ Residenc 28d. Describe how	
N N	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu		28e. Place of Injury - At home, farm, st building, etc. (Specify)  29a. Certifier (Check only 2   Medical Examiner: On the basis of examination and/or in	th occurred at the time, date and place, a	City or Town, S	e(s) and manner as stated.
)	To the H within 24 To the Fi complete	Medical	29b. Signature and title of certifier	29c. License number  D 0060478	29d.	Date signed (Month, Day, Year)  BRUARY 4, 2005
	Sta	ite	30. Name and address of person who completed cause of death (Item 23a) (Type.  DR. AFAO AHMAD, 625 KENT AVE., CUMBER  31. Date filed (Month) Average 32 Soutrar's Signature			
	Registi		31. Sale lied (MSM) 44.91.3 2805	and a		

			1 - For State Registrar	State of M	arylan		artment rtificate			and Me		/ /	005	16308				
	Physici		1. Decedent's Name (First, Middle, La Clarence Earl	Hicks							2. Date of De. April		2005°	3. Time of Death 3:45A. M				
	/Medic Examir		4a. Facility Name (If not institution, given 13114 Taney Driven	re street and number) 7 <b>e</b>				rown, or tsvi	Location o	of Death		4c. C	County of Death					
	Funeral Director		233-56-0536	Sex 7. Ag 1 ☑ M 2 □ F		ast birthday) 68 Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Birt (Month, Da March9	h Year) , 1937	9. Birthp Coul West	place (State or Foreign ntry) Virginia				
	Maryland -f show	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland Prince	George's		tsvill								10d. Inside City Limits 1 ☐ Yes 2 ☐ No				
	h with the 23e or 28a st be notil	Funeral Director	10e. Street and Number 13114 Taney Driv	7e			10f. Zip	Code 0705				-	en of What Cour ted Sta	ntry?				
920	be filed within 72 hours after death with the Maryland ntal hygiene. ad other than "neturel", or fleme 23e or 28a-f show event, the Mudical Exertinger must be notified at	by Funer	11. Marital Status  1 Never Married  Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1  Yes 2 If Yes, Give Year or Dates:	,		Was Deceded Yes, special		spanic Origin, Mexican Specify:	gin? (Spec , Puerto R	city Yes or No- lican, etc.)		4. Race - Americ Black, White, Specify:	can Indian, etc. White				
21215-0036	d within 72 ho piene. r than "netur rne Medical	Completed by	15. Decedent's E (Specify only highest gn Elementary/Secondary (0-12)	ducation ade completed) College (1-4or	5+) 5+	(Give	dent's Usual kind of word DO NOT use rical	k done di e retired)	uring most		g	NSA		of Defense				
Maryland ?	2 should be filed within and Mental Hygiene. Is marked other than eumatic event, tre M	To Be C	17. Father's Name (First, Middle, Last Elmer Earl Hic		,				18. Mothe Emma		ame (First, Middle, Maiden Sumame) Katherine McGrew							
	Carolyn M. Hicks -wire 13114 Taney Drive Belt																	
Baltimore,	1 Burial 2 Operation 3 Removal from State 1 Donation 5 Other (Specify)  Metropolitan Crematory									4/28			ation - City or To andria,					
Balt	permit. Departimport any inj		21. Signature of Funeral Service Lice			13x	Shalad 400 Po	vderese wder	of Facility Organia	ardt 1 Roa	Funera ad Belt	l Hor	me, PA le, Mary	/land20705				
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8760,	ate be executed nysicien and he burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as														
P.O. Box 68	law requires that the death certificate be executed as been signed by the attending physicien and 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal	death 3[	Ectopic pre Other (spe					23	d. Date of delive	ery D <b>ay</b> Year				
	quires that en signed by	by	Part II. Other significant conditions of	contributing to death b	ut not resu	ılting in the u	nderlying ca	use give	n in Part I.					ne cause of death? ably 4 []Unknown				
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of	ding h. After fune	tlon: To	1  Yes 2 No  27. Manner of Death  1 Natural 5  Pending 2  Accident investigatio	28a. Date of Inju		ER/Outpatien 28b. Time of Injury		lc. Injury Work	"4□Nur at ? es 2□N	28	e 5 Resid		□Other (Specify occurred	/)				
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	To the Hospitel or within 24 hours after To the Funerel Dire completely filled in b	edical	29a. Certifier 1 Certifying Pt (Check only one) 2 Medical Example	nysician: To the best miner: On the basis o and manner st	f examinati	vledge, death ion and/or inv	occurred a restigation,	t the time	e, date and inion, deat	d place, an h occurred	d due to the o	ause(s) a date and p	nd manner as st lace, and due to	ated. the cause(s)				
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	toin, mo				License	272		2		signed (Month, 1					
	10		30. Name and address of person who Sally Cheston, MD	completed cause of c	leath (Item ctle 1	<sup>23а) (Туре,</sup> Patuxe	Print) nt Par	rkwa	y Cal	umbia	a. Mars	hasiv	21044					
	Sta Registr		Ot Date filed (Month Day Veed)	2005 32. Rejistr					,		~, y	-and	<u> </u>					

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an							ay Year	3. Time of Death
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	5. Social Security Number 6. Se	x 7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	Hours   Min.   (Month	i, Day, Yeai	9. Bir 938 WA	thplace (State or Fore
		100 0	Taura and a					
tor			•					10d. Inside City Lim 1 X es 2 □
Direc	10e. Street and Number			10f. Zip Code		10g. C	itizen of What Co	ountry?
rai								
Fune	11. Marital Status  1X□Xever Married 2□ Married	Armed Forces? 1 ☐ Yes 2\(\)\(\)\(\)\(\)		If Yes, specify Cuba	an, Mexican, Puerto Rican, etc.	r No- )	14. Race - Ame Black, Whit	
d by	3 Widowed 4 Divorced	Year or Dates:						HITE
plete	(Specify only highest grad	e completed)	(Give	kind of work done	during most of working	16b. I	Kind of Business	/Industry
Сош	10		RECE	IVING C				ERNMENT
Be							n Sumame)	
۲			19b. Mailie	ng Address (Street			or Town, State, .	Zip Code)
11 3	BENJAMIN HOWARD-	-BROTHER	1220	BENNET	r WAY #68, TE	MPLE	TON, CA	93465
	·		Place of Dispo	sition (Name of	Date			
	* 4 ☐ Donation 5 ☐ Other (Specify)	METROP	OLITI.	AN CREMA	ATORY 2-24-0	5 AL	EXANDR:	IA,VA
	21. Signature of Funeral Service Licens	<sup>60</sup> MOO479				TCE	DΛ	
	Mulal	0. 6	L	A PLATA	- MARYLAND	2064		
	shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ne cau <del>se o</del> n each line.  / Gastro	intest		-Lorenza - compar	Y G	line	Approximate Interval Between Onset and Death
		D						
mlne	cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	tuerios city.		11/	1	V-	R
	resulting in death) Last	Due to (or as a consec	quence of):		ANI APP	ROVED BY I	MEDICAL EXAMINA	
		d			RTIF CATION AS			
ysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \( \text{Yes} \) 2 \( \text{No} \) 8 \( \text{Unknown} \)	1 ☐ Live birth 2 ☐ Feta	aldeath 3[				23d. Date of del Month	livery Day Year
y Ph		1 1		, .		oid tobacco	use contribute to	the cause of death?
ted t							2□No 3□Pr	obably 4 Unknow
Complet	Chronic obstruct	ive pulmonary	disea	se; Couma	a	utopsy erformed?	death?	utopsy findings availat completion of cause of
	avaminer?					nly one)		
L <sub>O</sub>	1 X es 2210	1 1 inpatient 2 L		. 500501	+ Littershing Floring			cify)
ion:	1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury			ibe how inju	ry occurred	
ertificat	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, str fy)		28f. Location	on (Street a Town, Stat	nd Number or Ru e)	ural Route Number,
	29a. Certifier (Check only one)  1 Certifying Physical Exemi	sician: To the best of my kno ner: On the basis of examina and manner stated.	owledge, deati ation and/or in	n occurred at the tin vestigation, in my o	ne, date and place, and due to pinion, death occurred at the til	the cause(s	s) and manner as od place, and due	stated. to the cause(s)
Me	29b. Signature and title of certifier		1	29c. Licens	e number	29d. Da		
	co	v Shy	2	_ D006	0456		2/17	105
	30. Name and address of person who co							
	o Be Completed by Physician/Medical Examiner To Be Completed by Funeral Director	ROBERT HENRY HO  4a. Facility Name (If not institution, give  CIVISTA MEDIC  5. Social Security Number  218-34-1929  Usual Residence of Decedent  10a. State  10b. County  MARYLAND CHARLES  10e. Street and Number  1 HICKORY LANE,  11. Marital Status  (Specify only highest grad  Elementary/Secondary (0-12)  17. Father's Name (First, Middle, Last)  ROBERT H. HOWARD  20a. Method of Disposition  1 Burial Moremation 3 Formation 3 Formation 5 Other (Specify)  21. Signature of Funeral Service Licens  23a. Part. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, Isabing to immediate cause (Final disease or condition resulting in death)  FFEMALE:  23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No  9 Unknown  Part II. Other significent conditions con Hypertensive ather Chronic obstruct  Chronic obstruct  1 Natural Suicide Gould not be determined  2 Accident Suicide Gould not be determined  2 Accident Suicide Gould not be determined	AL Facility Name (If not institution, give street and number)  CIVISTA MEDICAL CENTER  5. Social Security Number  6. Sex XXM 2 F  6. MARYLAND CHARLES  Usual Residence of Decedent  10a. State  10b. County  MARYLAND CHARLES  L  10c. Street and Number  1 HICKORY LANE, APT. #201  11. Marital Status  12. Was Decedent Ever in L Amned Forest?  13. Widowed 4 Divorced  14. Sea Silve  14. Sea Silve  14. Sea Silve  15. Decedent's Education  (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  10  17. Father's Name (First, Middle, Last)  ROBERT H. HOWARD, JR.  19a. Informant's Name/Relationship (Type, Print)  BENJAMIN HOWARD—BROTHER  20a. Method of Disposition  1 Burial 2 Demantion 3 Removal from State  4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee MOO 4.79  23a. Part Lenier the disease, or complications that caused the dea shock, or heart failure. List only one cause-on each line. Shock or heart failure. List only one cause-on each line. Shock or heart failure. List only one cause-on each line. Shock, or heart failure. List only one cause-on each line. Shock or heart failure. List only one cause-on each line. Shock or heart failure. List only one cause-on each line. Shock or heart failure. List only one cause-on each line. Shock or heart failure. List only one cause-on each line. Due to (or as a consect cause Enter Underlying that initiated events, pury tha	ROBERT HENRY HOWARD, III  4a. Facility Name (if not institution, give street and number)  CIVISTA MEDICAL CENTER  5. Social Security Number  6. Sex XIX 2 7. Age (in yrs. last birthday)  218-34-1929 XIXM 2 F 66 Yrs.  10a. State 10b. County 10c. City, Town or Let 10a. State 10b. County 10c. City, Town or Let 10a. State 10b. County 10c. City, Town or Let 10a. State 10b. County 11c. Street and Number 11c. APT. #201  11. Marial Status 11c. Wildever Married 2 Married 3 Wildowed 4 Olivorced 11c. Specify only ingrest grade completed)  11. Was Decedent Ever in U.S. Amed Forces? 11c. Yes 2 Mol. 11c. Yes 2 Mol	ROBERT HENRY HOWARD, III  4a. Facility Name (If not institution, pive street and number)  CIVISTA MEDICAL CENTER  1. A PL  S. Social Southy Number  2. 18 – 34 – 1929  Usual Residence of Decedent  1. 10a. State  10b. County  10c. City, Town or Location  LA PLATA  10c. Street and Number  1. HICKORY LANE, APT. # 201  1. Marital Status  COMever Married  3   Widowed 4   Devocadent a Education  (Specify only highest prade completed)  1. 1. Marital Status  (Specify only highest prade completed)  1. 1. Father's Name (First, Middie, Last)  1. 2. Was Decedent III.  1. 1. Marital Status  (Specify only highest prade completed)  1. 1. Father's Name (First, Middie, Last)  1. 2. Was Decedent Ever in U.S.  1. 1. Marital Status  (Specify only highest prade completed)  1. 1. Father's Name (First, Middie, Last)  1. 1. Status (Specify Cub)  1. 1. Father's Name (First, Middie, Last)  1. 2. Was Decedent Ever in U.S.  1. 1. Marital Status  (Specify only highest prade completed)  1. 1. Father's Name (First, Middie, Last)  1. 2. Marital Status  1. 2. Marital Status  1. 1. Specify only highest prade completed (First, Middie, Last)  1. 2. Marital Status  1. 2. Marital Status  1. 3. Was Decedent Ever in U.S.  1. 4. Decedent's Education  (Specify Conly highest prade completed)  1. 4. Decedent's Specify (Cub)  1. 7. Father's Name (First, Middie, Last)  1. 8. Marital Status  1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1	ROBERT HENRY HOWARD, III  Raelity Name (if not institution, give stress and number)  CIVISTA MEDICAL CENTER  1. A PLATA  5. Soos Security Number  218-34-1929  NAM 20 F 66 vs.  Months Days Hours Win Ludger 28 Hst. 8. Date of vs.  Worths Days Hours Win MAR.  100. Stress and Number  100. Stress and Number  100. Stress and Number  100. Stress and Number  11. Warrant Status  12. Was Decedent Ever in U.S.  13. Was Decedent of Hapapac Origin? Specify vs. or U.S.  14. Was Decedent Ever in U.S.  15. Decedent Exception  (Give seried decedent of Hapapac Origin? Specify vs. or U.S.)  10. Stress and Number  10. Stress and Number  10. Specify only highest grades completed;  (First, Med.  10. Stress and Number of New Norway Decedent Ever in U.S.)  11. Was Decedent Ever in U.S.  12. Was Decedent Ever in U.S.  12. Was Decedent Ever in U.S.  13. Was Decedent Ever in U.S.  14. Decedent Ever in U.S.  15. Decedent Ever in U.S.  16. Decedent Ever in U.S.  16. Decedent Ever in U.S.  17. PLATA  199. Mailing Address (Smeat and Number or Rural Route in U.S.  189. Mailing Address (Smeat and Number or Rural Route in U.S.  199. Mailing Address (Smeat and Number or Rural Route in U.S.  199. Mailing Address (Smeat and Number or Rural Route in U.S.  10. Place of Deposition  10. Place of Deposition  10. Place of Deposition (Plane of Deposition Plane of Depos	ROBERT HENRY HOWARD, III Feb. 17  46. CIVISTA MEDICAL CENTER  S. Social Socially Number	ROBERT HENRY HOWARD, III Feb., 17  2005  49. Fig. 7, Fow, or Location of Death CIVISTA MEDICAL CENTER  5. Social Security Number  6. Sex 218 - 34 - 1929  2007  40. City, Tow, or Location of Death MARYLAND  5. Social Security Number  6. Sex 218 - 34 - 1929  2007  40. City, Tow, or Location of Death MARYLAND  CHARLES  LAPLATA  100, State 100, City own or Location  MARYLAND  CHARLES  LAPLATA  101, 2p. Code  100, City own or Location  MARYLAND  CHARLES  LAPLATA  101, 2p. Code  100, City own or Location  MARYLAND  CHARLES  LAPLATA  102, 2p. Code  103, City own or Location  MARYLAND  CHARLES  LAPLATA  104, 2p. Code  105, City own or Location  MARYLAND  CHARLES  LAPLATA  105, 2p. Code  106, City own or Location  MARYLAND  CHARLES  LAPLATA  107, 2p. Code  109, City own or Location  MARYLAND  CHARLES  LAPLATA  100, City own or Location  MARYLAND  CHARLES  LAPLATA  100, Specific own or Location  110, City own or Location  MARYLAND  110, City own or Location  MARYLAND  110, City own or Location  110, City own or Loc

				1 1003					Health and M			ibic.		
				for State Registrar			•	ertificate of			Reg. No.	05	163	10
				Decedent's Name (First, Middle,	Last)					2. Date of Dea		Vaar	3. Time of I	Death
		Physici /Medio		RUSS	SELL	ALI	DEN	HERR	ICK	May	6, 2	2005	3:10	AM
		Examin		4a. Facility Name (If not institution,					or Location of Death		4c. Coun	ty of Death		
				Upper Chesape 5. Social Security Number			Cent		Bel Air		h		ford	Foreign
	П	Funeral Director		122-22-4467	1 <b>X</b> M 2□F	94	Yrs.	Months Days		8. Date of Birt (Month, Date 8/18/1	Year)	New	place (State or ntry) Y York	roreign
		D		Usual Residence of Decedent						0/ 10/ 2				
		arylar show	_	10a. State 10b. County	. 6 3	10c. Ci	ty, Town or L	ocation	Da7 44				10d. Inside Cit 1 ∐Yes	144
		death with the Maryland ms 23a or 28e-f show rroust be rediffed at	Funeral Director	MD. Has	rford			10f. Zip Code	Bel Ai		10g. Citizen o	f What Cou		
0		with t	Dir	204 Chaucer	Lane			TOI. ZIP COde	21014				tates	
0310		death ms 23	nera	11. Marital Status	12. Was Decede	nt Ever in U	I.S. 13	. Was Decedent of	Hispanic Origin? (Spoan, Mexican, Puerto	ecify Yes or No		ace - Ameri	can Indian,	
0	ဖွ	or Ita	Fur	1 Never Married 2 Marrie	Armed Force d 1 XYes 2[ If Yes, Give Year or Date	S? ⊒No		1 Yes 2 No		Rican, etc.)	Spec	ack, White,		
	93	ural',	d by	3 ☐ Widowed 4 ☐ Divorced		s:WW .	II					11	hite	
	15-	n 72 h	Completed	15. Decedent's (Specify only highest	grade completed)		(Giv	edent's Usual Occu e kind of work done DO NOT use retire	during most of work	ing	16b. Kind of	Business/In	idustry	
	212	withi iene. r then	шо	Elementary/Secondary (0-12)	College (1-4d	or 5+)			eacher		F	lduca	tion	
	٦	e filed at Hyg otha vant,	BeC	17. Father's Name (First, Middle, L.	ast)		-		18. Mother's Name	e (First, Middle,	Maiden Suma	ime)		
	ylaı	Menta Menta Brked	To	Harry			Herr		Ella				den	
10	Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If itam 27 Is marked other then "natural", or Itams 23s or 28e-1 show any injury or other traumatic event, the Madical Example 1 will be inclined at once.		19a. Informant's Name/Relationshi					t and Number or Run	matters.				
0.5	e, P	1 and Health am 27 ther t		Jane W. Herr: 20a. Method of Disposition	ick / Wile			Chauce:		Unit I	20c. Location		r, Md	•
6	JO.	ages nt of h		1 Burial 2 ACremation	Removal from Sta	re.		osition (Name of ematory or other pla						7
5	Ħ	artme ortani injury		4 □Donation 5 □ Other (Special Signature) of Figure 3.		Ua.	roll	22. Name and Addr	ion 5/9/		Hamps			
V	Ba	permil Depar Impor any in		VIII. 19/11/	den Ku	nti-			urtz & S	rretts	sville	Home	ryran	a
				23a. Part1. Enter the disease, or c shock, or heart failure. List o	omplications that cause on each	sed the dea	th. Do not e					1101110	Approximate Interval Betw	
		Physician		Immediate Cause (Final disease or condition	-	1 /	EMP	YEMA					Onset and D	eath
		/Medical Examiner		resulting in death)	Due to (or		quence of): /	)	. ^		-		٦٠٠٠٠	, ,,,
	п	⊏xammer	L	Sequentially list conditions.	b			NEUMI	DNIA		-			
10	V	led Isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		as a consec		ZMPH4	SAU A					
30		axecun and and al-tra	Exar	that initiated events resulting in death) Last	c Due to (or	as a consec	quence of):	EMPHY.	714					
33	760,	ate be executed hysician and the burial-transit	call	,	d		*	PEMEN	′′′Т					
7	89	iffic g p		IE EENALE.				-			1			
#	Box	To the Hospitel or Attending Physician: The law requires that the death cerwithin 24 hours after death.  To tha Funaral Diractor: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcor 1 ☐ Live birth	2 Feta	al death 3	□Ectopic pregnanc	су			ate of deliver	•	ear
	O. E	the at	/sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□ Pregnant 9□ Unknown		death 5	Other (specify)			,	ionii i	buy .	ou!
	σ.	that the	Ph	Part II. Other significant condition	s contributing to deat	n but not res	sulting in the	underlying cause g	iven in Part I.	23e. Did to	obacco use co	ntribute to t	he cause of de	ath?
	ds,	uires I sign	d by							1 🗆 Y	res 2□No	30 Prol	bably 4 DU	nknown
	Vital Records,	s beer	Completed							24a. Was		. Were auto	opsy findings a	vailable
10556	Be	The la	mo								rmed?	prior to co death? 1 \( \subseteq \text{Yes}	mpletion of ca	use of
75.	ita	ian: rtifica ctor, p	Be C	25. Was case referred to medical					26. Place of Deat					
X	of V	Phyaician: r this certifica ral director,	To	examiner?	Hospital: Inpa		ER/Outpation	ent 3LIDUA	ther: 4 Nursing Ho				fy)	
X'		ing P After t unera	ion:	27. Manno of Death  Natural 5 Pending	28a. Date of I (Month,	njury Day Year)	28b. Time Injury	Wo	ury at ork? ☐ Yes 2 ☐ No	28d. Describe h	now injury occi	ırred		/
1,5	Division	Attending ir death. actor: After by the fune	icat	2 Accident investigation inves	ot be	Injury - At h	ome farm s	treet, factory, office		28f. Location (S	Street and Nun	nber or Run	al Route Numb	DB/.
Herrick,	Ο̈́	after Dirac	Certification:	4 ☐ Homicide determin	building,	etc. (Speci	<b>(y</b> )			City or Tox				
I		spite hours maral	alC		Physician: To the be									
		To the Hospitel or Attendi within 24 hours after death. To tha Funaral Diractor: A completely filled in by the fu	edical	(Check only 2 Medical E	xaminer: On the basis and manner		ation and/or	nvestigation, in my	opinion, death occur					
		To T To 1	Σ	29b. Signature and title of certifier	Lan	dA	ω		80		29d. Date sign		Day, Year)	
		1+1		Pour	-4200				50	U	5/6/0	-) 		
		6		30. Name and address of person w				9, Print) 2 <b>CHUILLE</b>	Rd	REIA	70	Md Z	21011.	
		Sta	ate	31. Date filed (Month, Day, Year)	32. Pag	istrar's Sign	ature	A TOTALE	-C(	٠٠٠)	VIIC .		7	
		Regist		MAY 13	2005	we.	B A	Conti						

			a FOI	artment of Health and Mental I	Hygiene 005	6311
	Physici	an	1. Decedent's Name (First, Middle, Last)	2. Date o Month	Death Day Year	3. Time of Death
H	/Medic	al	Robert Anthony Jackson	April	28, 2005 4c. County of Dea	12:26 p. <sup>M</sup>
	Examin	ier	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death  Clinton	Prince Ge	
	Funeral		Southern Maryland Hospital Center   5. Social Security Number   6. Sex   7. Age (In yrs. last birthday)	If Under 1 Year   If Under 24 Hrs.   8. Date o		thplace (State or Foreign ountry)
	Director		214-11-9120 <sup>1</sup> ∑ M 2□ F 34 Yrs.	Months Days Hours Min. (Months Dec.		shington, DC
	pur A		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Le	cation		10d. Inside City Limits
	Maryla f sho	ō	MD Prince George's Brentwood			1X Yes 2 □ No
	r 28a-	irect	10e. Street and Number	10f. Zip Code	10g. Citizen of What C	ountry?
	th with	by Funerai Director	3609 Webster Street	20722	USA	
	ams	iner	11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces?	Was Decedent of Hispanic Origin? (Specify Yes o If Yes, specify Cuban, Mexican, Puerto Rican, etc.	No- 14. Race - Am Black, Whi	
36	s afte	y F.	1 ☐ Never Married 2X Married 1 ☐ Yes 2X No	1 ☐ Yes 2X No Specify:	Specify:	
215-0036	within 72 hours after death with the Maryland ene. then "netural", or itams 23a or 28a-f show the Macical Examiner must be notified at		15. Decedent's Education 16a. Dece	dent's Usual Occupation	16b. Kind of Business	White Windustry
215	hin 72 In "ne Medit	piet	(Specify only highest grade completed) (Give	kind of work done during most of working DO NOT use retired)		,,
21	ad with giene. er ther	Completed		stant Manager	Shoppers 1	Food
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hyglene. Ifem 27 is marked other than "netural", or items 23a or 28a-1 show item 27 is marked other than "netural", or items 23a or 28a-1 show other traumatic event, the Ms. dical Examiner must be notified at	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Mic		
ry la	should Ind Mening Ind Mening Indianatic	ြ	Robert Allen Jackson	Sheila Doog		Zin Code I
Ma	d 2 shouth and the and traumater		t in the second	00 Bald Eagle School Ro	-	
ē,	ges 1 and to Health If item 27 or other tr		20a Method of Disposition 20b. Place of Dispo	The state of the s	20c. Location - City of	
altimore,	0 0		1 X Burial 2 Cremation 3 Hemoval from State		Brentwood,	Marvland
alti	parmit. Page Department Important: Il any injury o		TOLC BILL	2. Name and Address of Facility Gasch's		
<u>m</u>	8 9 1 6 8		A Constance Tasch	739 Baltimore Avenue,	Hyattsville,	Maryland
П			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	er the mode of dying, such as cardiac or respirato	ry arrest,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	cubolin		Onset and Double
	/Medical Examiner		Due to (or a consequence of):			
	2 0 4	ë	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):	-		
	d d ansit	Examine	eause. Enter Underlying Cause (Disease or injury that initiated events			
o,	be executed sicien and burial-transit		resulting in death) Last Due to (or as a consequence of):			
8760,	ate hys	Physician/Medical	d			
9 хо	ding plans to se as t	/Mec	IF FEMALE: 23c. If yes, outcome of pregnancy		001 Day of the	P.
Bo	eath certific attending p for use as f	cian	in the past 12 months?	Ectopic pregnancy Other (specify)	23d. Date of de Month	Day Year
o.	at the de by the tached	hysi	1 Yes 2 No 9 Unknown			
, P.	res that igned to be deta	by P	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I. 23e. [	Did tobacco use contribute t	o the cause of death?
ecords,	w require baen sig should b				☐ Yes 2☐ No 3☐ P	robably 4 Unknown
ecc	e law re has ba je 2 sh	Completed			utopsy prior to	utopsy findings available completion of cause of
E B		Con			erformed? death? es 2 □ No 1 ☑ Ye	s 2 No
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?  Hospital:	26. Place of Death (Check of Death )		
of	Phys r this ral di	. To	1 X Yes 2 No	IL 3 DOA 4 Norsing Home 3 1	Residence 6 Other (Speibe how injury occurred	acify)
lon	Attending I r death. ector: After by the funer	ition	1 Natural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No	,,,,	
Division	or Attendi after death. Director: A in by the fu	ifica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st		on (Street and Number or Fi	ural Route Number,
Ö	tal or A	Certification;	4 Homicide Scientified building, etc. (Specify)	Ony of	Town, State)	
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edicai	29a. Certifier (Check only (Ch			
	To the He within 24 To the Fu	Med	one) and manner stated.  29b. Signature and title of certifier	29c. License number	29d. Date signed (Mon	th. Dav. Year)
	7 ≥ 8		July 1	OCME	April 29	*
0	[7]		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)		
	(I)		THE SMAT M. Vino	111 Penn Street Balti	more, Marylan	nd 21201
	Sta	ite	31. Date filed (Month, Day, Year)  39. Registrar's Signature			
	Registr		MAY 0 2 2005 Keen & 65	W.		

		ľ	For State Registrar	State of Ma		d / Depa		t of He	ealth a		ental Hy		-200	5 16312
	Physici /Medio Examin	al	Decedent's Name (First, Middle, Lass     Mary Elizebeth      Facility Name (If not institution, give	Jones e street and number)					Location of	of Death	2. Date of De. Month 04 - 2	27 – 40	2005 County of Dea	
	. Funeral Director	5	5909         Charnwood           5. Social Security Number         6. Social Security Number           578-16-7010         1           Usual Residence of Decedent	Road ex 7. Age □M 松口F	(In yrs. Ia	ast birthday) Yrs.	tf Under Months	nsvi 1 Year Days	II e If Under Hours	Min.	8. Date of Bir (Month, Da August	h y, Year)	altimor <sup>9. Bir</sup> 1935Was	thplace (State or Foreign ountry)
	the Maryland 28e-f show	Director	10a. State 10b. County  Maryland Baltimo  10e. Street and Number			tonsv		Code				10g. Ci	tizen of What C	10d. Inside City Limits 1 ☐ Yes 2 ☐ No ountry?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Dep riment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23c or 28e-f show any njury or other traumatic avant, the Medical Extr. is ett, and the mofflind at ODGs.	Funeral	5909 Charnwood Ro  11. Marital Status  1  Never Married 2 Married	12. Was Decedent E- Armed Forces? 1 Yes 27 No If Yes, Give		i i	21	228 lent of His city Cubar	spanic Ori , Mexican Specify:		cify Yes or No Rican, etc.)		U.S.A.  14. Race - Ame Black, Whi Specify: B1	erican Indian, te, etc.
Maryland 21215-0036	d within 72 hours jiene. r than "natural",	Completed by	3 ☐ Widowed 4 ☑ Divorced  15. Decedent's Ec (Specify only highest gra  Elementary/Secondary (0-12)  12th	Year or Dates:		16a. Dece (Give life.	dent's Usua kind of wo DO NOT us ounta	al Occupa rk done di se retired)	uring mos	t of workir	g		(ind of Business	
ryland ?	hould be filed id Mental Hyg marked other matic avant,	To Be C	17. Father's Name (First, Middle, Last)  19a. Informant's Name/Relationship (7)	Henry Glo	ver	19b. Mailir	na Address		Mam	ie Le	(First, Middle, ee Pix1	ey	or Town, State,	Zip Code)
Baltimore, Ma	Pages 1 and 2 sent of Health and: If itam 27 is: If you other trau		Francine A. Franc  20a. Method of Disposition  1 Burial 2 X Cremation 3 Cremation 5 Other (Specify	Removal from State		5909	Chari Isvil Osition (Nari Thatory or o	NOOC Le, N ne of ther place	l Roa laryl	d and,	21228_ ate	20c. L	ocation - City or	
Baltii	permit. F Dep rum Importer any rijur once.		21. Signature of Funeral Service Licen	Bacon. C	CE	36136	2. Name an 447 1	d Address	s of Facilit	y W.H.	. Bacon .W. Was	Fun hin	neral H	Ome, Inc. .C. 20010
	Physician /Medical		23a. Part1. Enter the disease, or com, shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused to one cause on each line a. Rena1  Due to (or as a	Fai	llure	ter the mod	e of dying	, such as	cardiac o	respiratory a	rrest,		Approximate Interval Between Onset and Death Years
3760,	icate be executed by physician and burial-transit the burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Diabet  Due to (or as a  c. Due to (or as a	consequ	ence of):	tus							Years
.O. Box 68	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as if	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome o 1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	Fetal	death 3[	⊒Ectopic pr ⊒ Other (sp						23d. Date of de Month	livery Day Year
S, D	equires that item signed by ould be deta	by	Part II. Other significant conditions of Ischemic Card	contributing to death but	t not resu	lting in the u	nderlying c	ause give	n in Part I					o the cause of death?
Vital Record	in; The law r ificate has be or, page 2 sh	e Completed	25. Was case referred to medical						as Plans	of Doath	24a. Was autop perfo	rmed?	prior to	utopsy findings available completion of cause of
Division of Vi	To the Hospital or Attanding Physician: The law within 24 hours after death. To the Funaral Diractor: After this certificate has completely filled in by the funeral director, page 2	Certification; To Be	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 2 Accident investigation 3 Suicide 6 Could not be	0	Year)	28b. Time o Injury	M Z	8c. Injury Work 1  Y	r: 4 □ Nu	rsing Hon 2 No	ne 5 Residente 1	dence now inju		ural Route Number,
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	To the within 2 To tha complet	Med	29b. Signature and the of certifier  All 1	and manner state	1	23a) Type,	ME	257					ate signed (Mont	th, Day, Year)
<	Sta Regist		H. Brandis Mars 31. Date filed (Month, Day, Year) MAY 0 2 2005	h,MD 106	Irvir r's Signat	n Stre	et N.	W	Washi	ingto	n, D.C	. 20	0010	

			For State Registrar	State of	Marylan		artment of H		d Mental Hy	giene	nos	10010
	Physici	an	1. Decedent's Name (First, Middle, Las	,				_	2. Date of De Month	eath Day	Year	3. Time of Death
	/Media	cal	JUNG	SUN	41		UN	-1 (D	APRIL	27	2005	12:30 P
	Examir	er	4a. Facility Name (If not institution, give 440 UNIVERSITY				4b. City, Town, o	r Location of De ER SPRI		1	County of Death	
			5. Social Security Number 6. Se		. Age (In yrs.	last hirthday)	If Under 1 Year				MONTGOM	
Н	Funeral Director			_M 2 <b>X</b> JF	89	Ven	Months Days		in. (Month, De NOV 18	iy, Year)		place (State or Foreign intry) F A
			Usuel Residence of Decedent							17	NON CI	EA
	anyland show		10a. State 10b. County		10c. Cit	y, Town or Lo	cation					10d. Inside City Limits
	with the Marylar a or 28a-f show	Director	MD MONTGOME	ERY		SIL	VER SPRI	NG				1 ☐ Yes 2X No
	th the	Jire	10e. Street and Number				10f. Zip Code			10g. Citiz	en of What Cou	untry?
	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show the Madical Examinar must be invilled at		440 UNIVERSITY	BOULEV	ARD		2	0901		K	OREA	
	r dez	Funerai	11. Marital Status	12. Was Deced Armed Ford	dent Ever in U. des?	.S. 13.	Was Decedent of H If Yes, specify Cubi	lispanic Origin? an, Mexican, Pu	(Specify Yes or No lerto Rican, etc.)	)- 1	<ol> <li>Race - Amer Black, White</li> </ol>	
36	or h	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 If Yes, Give			1 ☐ Yes 2√ No	Specify:			Specify:	
8	hour tural	d b	3 Widowed 4 □ Divorced	Year or Da	tes:			ation .		105 Kin		SIAN
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7	withi ene. than	mc	Elementary/Secondary (0-12)	College (1-	4or 5+)		EMAKER	-/			OWN HOM	┎
0	filed Hygin other		17. Father's Name (First, Middle, Last)			ILOTI	STAKLIK	18. Mother's N	Name (First, Middle			ь
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Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death wi of Health and Mental Hygiene. Item 27 is merked other than "natural", or Items 23a other traumatic event. The Madical Experies must be	-	19a. Informant's Name/Relationship (7	ype, Print)		19b. Maili	ng Address (Street		Rural Route Numb		Town, State, Zi	ip Code)
	1 and 2 Health a tem 27 is		SOO JUN/SON			3530	SCHUERMA	N HOUSE	DR, FAIR	RFAX.	VA 220	31
altimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or othar		20a. Method of Disposition		1 ~	lace of Dispo	sition (Name of matory or other place		Date		ation - City or T	
Ē	Pages ment of I ant: If its ury or o	,	1 X Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specify		tate		EAVEN CE	,	R 29, 200	)5	SILVER	SPRING, MD
a E	Departm Departm Importar any inju		21. Sign Tre Fundral Service Licens	0	7							HOME, INC.
m	\$ 0 E & 8		A. Kenth	1 5/m	N.	V / V						NG, MD 20904
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	Physician /Medical		disease or condition resulting in death)	a	or as a conseq		CINOMA OF	TUE ST	OPIACE			6 MOS
	Examiner				·	,						
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9	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	/Me	IF FEMALE:	22a If was auto	om a of aroons	1001						
Вох	attenc for us	Physician/Me	in the past 12 months?		th 2 ∐ Feta int at time of d	Ideath 3[	Ectopic pregnancy	/		2	3d. Date of deli- Month	rery Day Year
o.	the de	ysic	1 ☐ Yes 2 🛣 No 9 ☐ Unknown	9□ Unknov		eain 5	Other (specify) _					
0	res that the de signed by the a be detached t	h h	Part II. Other significant conditions co	ntributing to dea	ath but not res	ulting in the u	nderlying cause giv	en in Part I.	23e. Did	obacco us	e contribute to	the cause of death?
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Viita	siciar certif recto	Be	25. Was case referred to medical examiner?	Hospital:			at all pos Oth	or	Death (Check only			
Division of	Phys rat di	. To	1 ☐ Yes 2 🐔 No  27. Manner of Death	1 ∐ In 28a. Date of		ER/Outpatier 28b. Time o	" 3 DOA	4 🗆 INUISIN	g Home 5 X Resi			ify)
on	ding h. Afte fune	tion	1 Natural 5 Pending 2 Accident investigation	(Month	n, Day Year)	Injury	Wor	k? Yes 2 □ No		, ,		
S	Atten deat ctor: y the	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of	of Injury - At he	ome, larm, sti	eet, lactory, office		28l. Location (	Street and	Number or Ru	ral Route Number,
á	after after Dire	Certification:	4 Homicide	buildin	g, etc. (Specif	y)			City or To	wn, State)		
	psplta hours inera y fille		29a. Certifier & Certifying Phy	sician: To the l	best of my kno	wledge, deat	h occurred at the til	ne, date and pla	ace, and due to the	cause(s)	and manner as	stated.
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medicai	(Check only 2 Medical Exemone)	and mann		tion and/or in	vestigation, in my o	opinion, death of	ccurred at the time,	date and	place, and due	to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	2 -	1 5		29c. Licens			29d. Date	signed (Month	Day, Year)
•			1 Jane 1	80		}	D-1	9250		4	120/0	2
	2		30. Name and address of person who o									
			DR. JAE SUNG CH	20 👫	mintendo Cinos	Acces		#306, L	ANHAM, MI	207	06	
	Sta Regist		31. Date filed (Month Day, Year)	005	Gustrar's Signa	K A	sell					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month. **Physician** 12:40 M 2005 atherine /Medical 4c. County of Death acility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Cheve ( 7. Age (Infyrs. last birthday) GEORGE. Tince Birthplace (State of Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Ci Days Hours Min 1□M 2XF 745 09 537 Usual Residence of Decedent Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or Items 23e or 28e-f show eny injury or other treumatic event, the Medical Examinary and pages. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Yes 2□No Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Was 20 Completed by Funeral 10104 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Black Specify 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 125 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sugname) To Be Cobb 19a. Informant's me/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ObD Nephew 10104 20b. Place of Disposition (Name of ,cemetery, crematory or other place) od of Disposition 1 Burial 2 Cremation 4 Donation 5 Other ( 3 Removal from State 30-2005 5 Cher (Specify) eral Service L or complications that caused the death. Do not enter ist only one cause on each line. 23a. Part1. Er ter try diser shock, or hear failur Approximate Interval Between Onset and Death disease or contion resulting in dotth) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit Cause (Disease or injury that initiated events the attending physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕱 No Month Dav Year 4 Pregnant at time of death 5 Other (specify) been signed by should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 X No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate has autopsy 2 No 1 Yes Hospitel or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Hospital: 1 ☐ Yes 2 No Certification: To 1 🗌 Inpatient 2 ER/Outpatient 3 □ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28d. Describe how injury occurred Manner of Death 1 X Natural 5 Pending 1 🗀 Yes 2 🗌 No 2 Accident investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospitel within 24 hours at To the Funerel E 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D45341 person who completed cause of death (Item 23a) (Type, Print) 30. Name and address CHEVERLY 3001 HOSPITAL JAMES AKR45 MD 31. Date filed (Month, Day, Year) Registrar's Signature State 2005 Registrar

Prysician (Medical Examiner Processor Of Section of Post Cargo Personal Processor Of Section of Post Cargo Personal Processor Of Section Of Sec				1 - For State Registrar	State of	Maryland / Depa		of Healtl			giene Reg. No.	05	16315
Christes W. Lezollar Service Control C	П	Physici	ion	1. Decedent's Name (First, Middle,	Last)							Year	3. Time of Death
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So South Security Number  1 So		Examir	ner			per)			on of Death		_		
23.2-6.7-273     M. REF						Ane (In we last hirthday)			der 24 Hrs	9 Date of Bird			
Top   Section   Top   Sectio		Director		133-26-7273					rs Min.	(Month, Day	v, Year)		
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23a Part I, first the disease, or complications that object the mode of dying, such as cardiac or respiratory arrest.  Approximate the mode of dying, such as cardiac or respiratory arrest.  Immediate Cause First Underlying immediate Cause First Underlying one cause on each first disease or condition. Security of the cause of conditions and conditions. Security of the cause of conditions are consequence of):  Breast Cancer in the Pelvis, involving Cecum, Rectum & Distal Illeum Distal Cancer (and the cause of conditions). The past 12 months?  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Diabetes Mellitus  25b. Was adecedent pregnant in the past 12 months?  9 Junknown of Diabetes Mellitus  25c. Place of Death (Cheek only one)  25d. Was case referred to medical avantment of the cause of conditions contributing to death but not resulting in the underlying cause given in Part I.  Diabetes Mellitus  25c. Was case referred to medical avantment of the cause of conditions and contributing to death but not resulting in the underlying cause given in Part I.  Diabetes Mellitus  25c. Was case referred to medical avantment of the cause of conditions and contributing to death but not resulting in the underlying cause given in Part I.  Diabetes Mellitus  25c. Place of Death (Cheek only one)  25d. Accident investigation of the cause (and the cause of contributions of the cause of conditions and contributions of contri	Ë	Page 1. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2.				ara	-		1 -	·	Alexan	dria.	Virginia
22. 2. Part   Knort he disease, or complications that Quested the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval 80 onset and disease or condition (section) in death of the property	Balti	permit. Departm Importa any inju								uneral	Home	Inc.	
Sequentially list conditions, family leading to immediate Cause (Disease or in Part I. Due to (or as a consequence of):    Part			shock, or heart failure. List of Immediate Cause (Final disease or condition	nly one cause on eac a. <u>Cervi</u>	ised the death. Do not ententh line.							Approximate Interval Between Onset and Death	
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Hypertension   Hype		uted d ansit	mlne	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Metasta		the Pel	vis, inv	olving (	Cecum, Re	ectum &	Distal	Ileum
25. Was case referred to medical examiner?  1   Yes   2   Xes   Xe	,092	ite be exec iysician an ne burial-tr			Due to (or	as a consequence of);							
25. Was case referred to medical examiner? 1   Ves 2   No  1   Ves 2   No  27. Manner of Death 1   Natural 5   Pending investigation 3   Suicide 4   Homicide 4   Homicide 4   Homicide 4   Homicide 4   Homicide 5   Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  28. Place of Death (Check only one)  28. Describe how injury occurred work? M 1   Yes 2   No  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)	.O. Box 68	the death certifica y the attending ph tched for use as th		23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnan	h 2 ☐ Fetal death 3 ☐ nt at time of death 5 ☐							*
25. Was case reterred to medical examiner?  1   Yes 2   Xe   No   Hospital:   I   Inpatient   2   ER/Outpatient   3   DOA   Other:   4   Nursing Home   5   Residence   6   Other (Specify)    27. Manner of Death   1   Natural   5   Pending investigation   3   DOA   Other:   4   Nursing Home   5   Residence   6   Other (Specify)    28a. Date of Injury   28b. Time of Injury   28b. Time of Injury   28c. Injury at   28d. Describe how injury occurred    28f. Location (Street and Number or Rural Route Number of Building, etc. (Specify)    29a. Certifier   1   Xecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier   29c. License number   29d. Date signed (Month, Day, Year)    30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	rds, P	quires that on signed b uld be deta	by		s contributing to deat	th but not resulting in the u	nderlying cau	se given in Pa	art I.		_		
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B D20274 April 27, 2005  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		he Hosp. in 24 hou ha Funar sletely fill	edical	(Check only 2 Medical E	xaminer: On the basi	is of examination and/or in	occurred at vestigation, in	the time, date my opinion, o	and place, and death occurre	nd due to the o	ause(s) and late and plac	manner as s e, and due to	tated. the cause(s)
30, Name and address of person who completed cause of death (term 25a) (Type, Fifth)	•		M	29b. Signature and title of certifier	Vok	re M.	29c. t			4			
Kirti Vohra MD 7710 Bradlow Blood Bothood No 20017		8		30. Name and address of person w  Kirti Vohra, M			-	-550	MD 200	17			
Kirti Vohra, MD 7710 Bradley Blvd., Bethesda, MD 20817  State Registrar  APR 2 9 2005  State Registrar  State Registrar  APR 2 9 2005								esua,	MD 708	1/			

			For Amend Items	State of Maryland,		•	rgiene	16016
	Physici /Medio	al	1. Decedent's Name (First, Middle, Last)  WILMER  4a. Facility Name (If not institution, give str	ENARIGUEZ	LOPEZ	2. Date of Do Month	eath Day Year	3. Time of Death
1	Examir Funeral Director	er	THE SOHN'S HOP  5. Social Security Number  213-47-8470  1X	KINS HOSPIT	TAL BALTIN	MORE CITY		halana (Stata or Foreign
	Maryland -f ahow	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland Prince G	10c. City, Tow	n or Location  Iyattsville			10d. Inside City Limits 1  Yes 2 □ No
	th with the 23s or 28s	Funeral Director	10e. Street and Number 627 Sheridan Stre	et; Apt. 13	10f. Zip Code <b>207</b> 8	83	10g. Citizen of What Co	•
920	perrit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23e or 28e-f ahow any injury or other traumatic avant, the Mydical Examinate rulat be mailted at Ance.	by	11. Marital Status 12  1 X Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1	13. Was Decedent of H If Yes, specify Cuba 1X Yes 2 □ No	lispanic Origin? (Specify Yes or N an, Mexican, Puerto Rican, etc.)  Specify: Salvadoriar		
21215-0036	within 72 ho ene. than "natur ne Modical	Completed	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12) <b>9th grade</b>	tition 16a. Completed) College (1-4or 5+)	Decedent's Usual Occup (Give kind of work done life. DO NOT use retired Unemploy	ation during most of working d)	16b. Kind of Business/	Industry
Maryland 2	ould be filed   Mental Hygi harkad other  atic avant,	To Be Co	17. Father's Name (First, Middle, Last)  Abilio Lopez				Fuentes	
	and 2 sho ealth and m 27 is ma har trauma		19a. Informant's Name/Relationship (Type Elsy Lopez Flores	(Sister) 62	0 Sheridan	and Number or Rural Route Numb Street;Apt.218;F	lyattsville,	Maryland
Baltimore,	perruit. Pages 1 Depurtment of H Impurtant: If itel any injury or ottl once.		20a. Method of Disposition  1	moval from State Cemen	f Disposition (Name of ry, crematory or other place terio Calis	Feb.5,2005	San Alejo, El Salvado	
Bal	Deper Import any ir		21. Signature of Funeral Service Licensee	D. Journ	600 Kenne	ss of Facility Z Funerarios Sen dy Street,N.W.;V	Washington,D	
	Pnysician /Medical		23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	cause on each line.  SEPSTS  Due to (or as a consequence		g, such as cardiac or respiratory a	rrest,	Approximate Interval Between Onset and Death
	Examiner	iner	Sequentially list conditions, I a y, leading to immodule cause. Enter Underlying Cause (Disease or injury that initiated events c.	ANOXIC B	50)	JURY	,	WESK
,092	rcate be executed physician and s the burial-transit	cal Examiner	that initiated events resulting in death) Last	Due to (or as a consequence PERFORATE	of);	N PONADE	BY MEDICAL EXAMINER	I WEEK
.O. Box 68	certif oding use as	Completed by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of pregnancy 1 \( \subseteq \text{Live birth} \) 2 \( \subseteq \text{Fetal death} \) 4 \( \subseteq \text{Pregnant at time of death} \) 9 \( \subseteq \text{Unknown} \)	3 □Ectopic pregnancy 5 □ Other (specify)	CENTROATO ADDOONE	23d. Date of deli Month	ivery Day Year
9	w requires that the death been signed by the atter should be detached for u	ed by Pr	Part II. Other significant conditions control Hypertensive Atheros			00000	tobacco use contribute to Yes 2 No 3 □ Pro	the cause of death?
Records,		omplet	end-stage renal dise status post balloon		ena cava str	auto		topsy findings available completion of cause of
of Vital	ding Physician: The law h. After this certificate has I funeral director, page 2 s	To Be C	25. Was case referred to medical examiner?	spital: 3	utpatient 3 DOA	26. Place of Death (Check only	one)	
Division o	fing After fune	Certification:	27. Manner of Death  Lateral  Accident  3 Suicide 4 Homicide  5 Pending investigation 6 Could not be determined	01/14/2005 Unl 28e. Place of Injury - At home, fa building, etc. (Specify)	Time of njury 28c. Injury Work KNOWNM 1	Yes 2 No duri 28f. Location ( City or To	how injury occurred or vena cava n; rocedure Street and Number or Ru wn, State Hopkins Hosp	eral Route Number,
	To the Hospital or Attand within 24 hours after death To the Funaral Diractor: completely filled in by the	Medical Co	29a. Certifier (Check only one)	Hospital  cian: To the best of my knowledge  or: On the basis of examination an and manner stated.	a, death occurred at the tin ad/or investigation, in my o	ne, date and place, and due to the	cause(s) and manner as	stated.
	To the within 2 To the complet	Me	29b. Signature and title of certifier		29c. Licenso		29d. Date signed (Month	
L	(2)		30. Name and address of person who com		(Type, Print)	RTH WOLFE STREET	Sanuary 2	21287
	Sta Registr		31. Date filed (Month, Day, Year) FEB 0 1 2005	2. Registrar's Signature	fole	KILL TOURTE SIKEE!	DALIJAIOK	, almay LAND ()

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 🥌 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) APRIL 30, 2005 **Physician** 0900 MILLER AT.IIII. HAWKINS /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner EASTON TALBOT WILLIAM HILL MANOR | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | JULY 23, 19 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 96 1908 **NEW JERSEY** Director 218-16-5919 Usual Residence of Decedent within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits it. Pages 1 and 2 should be filed within 72 hours after death with the Maryla ritnent of Health and Mental Hygiene.
rient: If itam 27 is marked other than "natural", or items 23a or 28a-f shov njury or other traumatic event, the Madical Examiner must be notified at XXYes 2 No MD. TALBOT EASTON Director 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 21601 501 DUTCHMANS LANE U.S.A. Funerai 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2**XX**No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes XXNo Specify: WHITE Completed by 3 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) OWN HOME 12 HOMEMAKER 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be JULIA DAVENPORT WILFORD J. HAWKINS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 208 S. HANSON STREET, EASTON, MD. 21601 DAVID F. MILLER / SON 20b. Place of Disposition (Name of Date 20c, Location - City or Town, State 20a. Method of Disposition CHESAPEAKE CRM. CTR. 5-2-05 STEVENSVILLE, MD. ortent: I injury o permit.
Deporte
Importe
any inji 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME P.A. Joseph M. Ostrountin 200 S HARRISON STREET, FASTON, MD. 21601 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month ğ 4☐Pregnant at time of death signed by the a d be detached f 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🗖 No 3 Probably 4 Unknown Completed W 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page )em entr 1 Yes 2 ☐ No 1 🗌 Yes 25. Was case referred to medical examiner? funeral director 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 4 Nursing Home 5 Residence 6 Other (Specify) 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After ospitar -4 hours after dec. - real Director: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 08715 25 Nelliam Joan 30. Name and address of person who completed cause of death (Hern 23a) (Type, Print) WILLIAM H. WOOD, JR. M.D. 501 DUTCHMANS LANE, EASTON, MD. 21601 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

Maryland 21215-0036

Baltimore,

P.O. Box 68760.

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 1 tem 26 per phys 9843 5-13-05 vt
State of Maryland 7 Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** ETHEL MARCH 2005 VIRGIE MUSGROVE 24, 1:50 P.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Shady Grove Adventist Hospital Rockville 7. Age (In yrs. last birthday)

84

Yrs.

| If Under 1 Year | If Under 24 Hrs. |
| Months | Days | Hours | Min. |
| FEB 22, 19 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 ☐ M 2 🛛 F 1921 218-30-8534 Director MARYLAND Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 27 is marked other then "natural", or items 23a or 28a-f ehow treumatic event, the Medical Examiner must be notified at 10b. County 1 Yes 2 No Director MONTGOMERY GAITHERSBURG MD the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7517 LAYTONIA DRIVE U.S.A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: WHITE à 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within hand Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HOME HOMEMAKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be BLAINE TEETER CORA ALICE SHREVES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) iges 1 and 2 sl of Health and it if item 27 is r DARLENE WILLIAMS/DAUGHTER ROUTE 2, BOX 391-2, ELKINS, WV 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【A Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any injury or once. CUMBERLAND CREMATORY 03/30/2005 4 ☐ Donation 5 ☐ Other (Specify) CUMBERLAND, 22. Name and Address of Facility
UPCHURCH FUNERAL HOME, P.A 21. Signature of Funeral Service Liven ee neuce 202 GREENE STREET, CUMBERLAND, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician neumor 1015 /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner law requires that the death certificate be executed as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 the attending physician Physiclan/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 Other (specify) detached P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ 3 Probably 4 Unknown 1 Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 1 Yes 1 Yes 2 No Division of Vital Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 

Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 funeral 27. Manns of Death 1 Natural 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After Certification 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 🗌 Homicide after within 24 hours a To the Funeret D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tever Ave. Olinst 31. Date filed (Month, Day, Year) gistrar's Signature State MAY 1 3 2005 Registrar

			For	State of M	larylar	d / Depa	artment o	of He	alth a	nd Me	ental Hy	giene	Logibio	-	
			for State Registrar			•	rtificate				-	Reg. No.			6319
	Dhysisi	2.5	1. Decedent's Name (First, Middle	e, Last)						1	2. Date of De	ath Day	y Ye		3. Time of Death
	Physici /Medic		Lafayette K. M								April	26,	2005	1	.2:55pm <sup>™</sup>
	Examin	er	4a. Facility Name (If not institution		•		4b. City, To			Death			County of D		
	Europe		Mariner Health 5. Social Security Number			last birthday)	Bet!	nesda Gear	a f Under 24	4 Hrs. 8	B. Date of Bir		ontgon	Birthplac	e (State or Foreign
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	shov	2		gomery		Boyds	cation							100.	. Inside City Limits 1 ☐ Yes 2 ☑ No
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pu	be file tal Hy d oth evant	Be	17. Father's Name (First, Middle,	Last)				18	3. Mother	's Name (	First, Middle	, Maiden	Sumame)		
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Maryland	id 2 sl th and th sist		Tarlouh Gasque	(Daughter)		7	0 Fest					-			000)
<u>6</u>	of Heelth ar itam 27 is othar tra		20a. Method of Disposition	<u> </u>	20b. F		sition (Name natory or othe			Da	te		cation - City		State
Ë	Peges nent of l ant: if it		1 🎇 Burial 2 □ Cremation  4 □ Donation 5 □ Other (S		3 1		s Cemet			April 2005	30,	Ger	mantow	m, M	ſd.
Baltimore,	permit. Peges 1 and 2 should be Department of Heelth and Menta important: if item 27 is marked any injury or other traumatic en		21. Signature of Funeral Service	License			. Name and A				1 Fun				
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	To the within Fo the	Me	29b. Signature and title of certifie	P	1	1	29c. L	icense n	umber			29d. Dat	e signed (M	onth, Day	y, Year)
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	1		30. Name and address of person		0	п 23а) Туре,	Print)								20052
			Dr. Anushirava 31. Date filed (Month, Day, Year)	n Dadgar M.			dical	cent	er D	r. #	ZUI Ro	ckvi	IIe, N	1d • 2	20850
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
RegistratVEND#14perINF4/29/05, BW, McCo Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Apri **Physician** 4:15**P**M Carrillo 2000 ar /Medical 4b. City, Town, or Location of Death County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** MUGTR auc If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days December Yrs. E1 Director Salvador Usual Residence of Deceden death with the Maryland 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location items 23a or 28a-f show if Health and Mental Hygiene. Item 27 Ia marked other than "natural", or Items 23a or 28a-1 shov other traumatic event. If a Medical Exact Fer inter the notified at 1 Yes 2 No Director Prince George's Brentwood 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 3709 40th Avenue 20722 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married WHITE 21215-0036 res 20 No Specify: Salva Joran þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5 Laborer Tree Service Maryland 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be pe Manuel De Jesus Merino Juana Carillo Pages 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3709 40th Avenue, Brentwood, Maryland 20722 if item 27 l Maria D. Villatoro/ wife Baltimore. 20b. Place of Disposition (Name of April 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) Department of Important: If it any injury or once. 1 Buriai 2 □ Cremation 3 Removal from State General Cemetery 2005 San Vincente, El Salvador ¹ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee, Francis Adress Corina Funeral Home Inc Wilhe 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical **Examiner** Sequentially list conditions, if any, leading to infine diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Completed by Physician/Medical Examiner The law requires that the death certificate be executed burial-transit Box 68760. attending physician for use as the buria IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) P.O. ed by the a detached f 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Other significant conditions contributing to death but not resulting in the underlying ca Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown CERTIFICAT 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy 2 No 1 Tes Fo the Hospital or Attending Physician: director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1. Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) \_2 🗌 No Certification: To 28a. Date of Injury (Month, Day) 28b. Time of Injury 28c. Inju 27. Manner of Death 28d. Describe how injury occurred After 5 Pending investigation 1 Natural rellon 2005 2 No death. UNKALLY 2 Accident after death | Director: / d in by the f e. Place of njury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Edgewa. Tel., MD 3 🗌 Suicide 6 ☐ Could not be determined 4 Homicide 2805 Apple CINNAMON PLace n 24 hours aft le Funeral Di letely filled in Outsid Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signature a 29c. License number 10 completed cause of death (Item 23a) (Type, Print) 25 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 2 9 2005

Registrar

Physici	_		e, Last)					2. Date of Dea		Year	3. Time of Death
/Medic		Donna	К.		Marto	ni		May 6,	2005	1001	2214 P
Examin		4a. Facility Name (If not institution ST • MARY S HOSE	, give street and numbe PTAL	er)		4b. City, Town, o LEONAF	or Location of De CDTOWN	eath	ST.	nty of Death MARY	S
Funeral Director		5. Social Security Number 579-04-4772	6. Sex 7. 1 ☐ M 2/€XF	Age (In yrs. last b	oirthday) Yrs.	If Under 1 Year Months Days	Hours Mi		1966	Çou	place (State or Fore ntry) yland
ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene.  I of Health and Mental Hygiene.  I of Health and Mental Hygiene.  I maked other than "natural", or items 23a or 28a-1 show or other traumatic event. The Medical Examination in the training of the contract of the	by Funeral Director	Usual Residence of Decedent  10a. State 10b. County  Maryland St. Ma	ary's	10c. City, To Mechan			-	<u>.</u>			10d. Inside City Lim 1 ☐ Yes 2 🔀
		10e. Street and Number				10f. Zip Code			10g. Citizen o	of What Cou	intry?
		41176 Queen Arbor C	Court			2065					
and Mantal Hygiene. Is marked other than "natural", or items: aumetic event. The Madical Examination		11. Marital Status  1 ☐ Never Married 2 Marr  3 ☐ Widowed 4 ☐ Divorced	12. Was Decede Armed Force ied 1 ☐ Yes 2% If Yes, Give Year or Date	s? XNo	"	Vas Decedent of I Yes, specify Cub ☐ Yes XX No	an, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. R B	ace - Ameri lack, White, cify: W	
e. an "natura Madical E	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	t's Education of grade completed)	16	(Give lite. L	ent's Usual Occu kind of work done OO NOT use retire	during most of v d)	working	16b. Kind of		ndustry
ygiene yer the t. Ins	Соп		5+ College (1-40	,	Regis	stered Nur				lical	
Mental H vrked oth	To Be (	17. Father's Name (First, Middle, Wayne A. Taylor	Last)					Name (First, Middle, ine A. Smith		ame)	
alth and 1 27 is me or traume		19a. Informant's Name/Relations David R. Martoni /						Rural Route Number Pechanicsvil			
Department of Health a important: If Item 27 is any injury or other training.		20a. Method of Disposition  1XXBurial 2 ☐ Cremation  4 ☐ Donation  ☐ Other (S)		cemet	tery, cren	sition (Name of natory or other pla orial Garde		Date 13, 2005	20c. Location Waldor	•	
Departm importa any inju once.		21. Signature Funeral Service	-	ė.	61	Name and Address Name Address N	ill Road	George P. K	las Fund aryland	eral Ho 20745	me P.A.
Pnysician /Medical Examiner		23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Combined Ethanol and Hydrocodone Intoxication  Due to (or as a consequence of):							Approximate Interval Between Onset and Death		
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ohysician and the burial-transit	dicai Examiner	Sequentially list conditions, and the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с	as a consequence	e of						
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n signed by the attending physician and uld be detached for use as the burial-transit	by Physician/Medicai	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1  yes 2 No	c	as a consequence me of pregnancy n 2 Fetel dea t at time of death n	e of : e of): th 3	Other (specify) _		23e. Did to	obacco use co	Month	Day Year
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n. After this certificate has been signed by the attending p funeral director, page 2 should be detached for use as	To Be Completed by Physician/Medical	25. Was case referred to medical examiner?  1X Yes 2 No  25. Wanner of Death  1 Natural  20 Accident  21 Accident  20 Accident  21 Accident  21 Accident  21 Accident  22 Accident  23 Accident  24 Accident  26 Accident  27 Accident  28 Accident  28 Accident  28 Accident  29 Accident  20 Accident  21 Accident  21 Accident  22 Accident  23 Accident  24 Accident  25 Accident  26 Accident  27 Accident  28 Acci	Due to (or d	me of pregnancy  1 2 Fetel death  2 House of death  h but not resulting	e of s:  e of s:  th 3 s  g in the un  Dutpatien	t 3 DOA	ven in Part !.  26. Place of Cher: 4 \( \text{Nursing} \)	24a. Was autoperio	obacco use co res 22 No an 24b sy rmed? 22 No ne)	ontribute to to 3 Professional Profession Pr	bably 4 Unknown of cause of cause of cause of death?
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hours after death. uneral Director: After this certificate has been signed by the attending p ly filled in by the funeral director, page 2 should be detached for use as	To Be Completed by Physician/Medical	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or d	as a consequence  me of pregnancy  2   Fetel dea  t at time of death  h but not resulting  atient 2X ER/C  njury  Day Year)  Injury - At home, etc. (Specify)  at home  ast of my knowled as sof examination a stated.	e of i: e of):  th 3 5  Outpatien Time of	t 3 DOA Ot 28c. Inju Wc 1 ceet, factory, office occurred at the trestigation, in my	26. Place of Deer: 4 Nursing Natrik?  Yes 2 No	24a. Was aytor Yes Death (Check only of 28d. Describe has 28d. Des	obacco use cover 2 No an 24th syyrmed? 2 No lence 6 Cover and Nur m, State 41 coving and an	ontribute to to a prior to code ath 2 to the result of the	bay Year  the cause of death? bably 4 Unknown  possy findings availal  possy f

			e of Maryland / Dep	partment of Health and I pertificate of Death	Mental Hygi	•	15222	
Physic /Medi		Decedent's Name (First, Middle, Last)     ROSENE		NICHOLSON	2. Date of Death Month APRIL 2	28 2005	3. Time of Death	
Examir		4a. Facility Name (If not institution, give street ar DOCTOR S COMMUNITY HO		4b. City, Town, or Location of Death  LANHAM	4c. County of De		eath GEORGE S	
Funeral Director		5. Social Security Number 6. Sex 1 M 25	7. Age (In yrs. last birthday 68 Yrs.	y If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, ) August	1936 9. Birth Cot 10 Nor	nplace (State or Foreign untry) th Carolina	
BaitImore, Maryland Z1Z13-UU30 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item Z7 is marked other then "natural", or items 23e or 28a-1 show eny injury or other treumatic event, the Medical Examinat the rolling at once.	ctor	Usual Residence of Decedent  10a. State 10b. County  MD Prince Georg	e s Lanha	m			10d. Inside City Limits 12 Yes 2 No	
	Funeral Director	7110 Goodluck Road		10f. Zip Code 20706	109	g. Citizen of What Cou	untry?	
	by Funer	1 Never Married 2 Married 1 If Ye	Decedent Ever in U.S. ed Forces? Yes 2 1 No es, Give or Dates:	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 1 ☐ Yes 2 ☒ No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Amer Black, White		
	Completed	15. Decedent's Education (Specify only highest grade comple Elementary/Secondary (0-12) Colle	edent's Usual Occupation e kind of work done during most of wor DO NOT use retired)	king	16b. Kind of Business/Industry			
	To Be Col	12th  17. Father's Name (First, Middle, Last)  David Nicholson	rtising  18. Mother's Nan  Pattie		Private  den Sumame)			
		19a. Informant's Name/Relationship (Type, Printernal Name/Relation	phew 5925 from State 20b. Place of Disposemetery, cree Rocky Mt	ematory or other place)  . Memorial 5/6/	Fredrick Date 20 2005 R B. Jenk	burg, Virgon City or Toocky Mt. Notins Funera	cinia 22407 Town, State Torth Carolinal Home	
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	Physician/Med	in the past 12 months?		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year		
# # B B	by	Part II. Other significant conditions contributing $\mathbf{HIV}$		id tobacco use contribute to the cause of death?				
HeC The taw te has b age 2 st	Completed	Carcinoid Tumor			24a. Was an autopsy performe	prior to co	opsy findings available ompletion of cause of	
	o Be	25. Was case referred to medical examiner?  1 \( \subseteq \text{ Yes} \) 2 \( \text{ No} \) Hospital:	1 <b>X</b> Inpatient 2 ☐ ER/Outpatie	Othor	th (Check only one)	ce 6 □Other (Speci	ifv)	
VISION OI Attending Phy ar death. ector: After this by the funeral d	ertification; T	27. Manner of Death  1 X Natural 2 Accident 3 Suicide 4 Homicide  28a.  Pending investigation  6 Could not be determined  28e.	28d. Describe how 28f. Location (Stre City or Town,					
To the Hospitel or within 24 hours afte To the Funerel Dir completely filled in	edical Ce	(Check only 2 Medicel Exeminer: On	To the best of my knowledge, dea the basis of examination and/or in manner stated.	th occurred at the time, date and place nvestigation, in my opinion, death occu	, and due to the cau rred at the time, date	se(s) and manner as s and place, and due t	stated. to the cause(s)	
To the within To the comple	Me	29b. Signature and title of certifier	3	29c. License number MDD 31069				
26		30. Name and address of person who completed George Bone M.D. 11		Print) ane Suite 135 Lar				
Sta		31. Date filed (Month, Day, Year)	37 Registrar's Signature	auf.)				

			For Stete Registrar	State o	of Maryland		artment of H		nd Men		ene	05	16'	323
H	Physicia	an	Decedent's Name (First, Middle     HELEN							Date of Death Month 4/24		Year	3. Time o	
	/Medic Examin	al	4a. Facility Name (If not institution		ımber)		4b. City, Town, o	r Location of I	Death	4/2	4c. County	of Death	1:52	AM^
			3310 N. LEISURE				SILVER S		4 Hrs. la	Date ( Dist	MONTG		(2)	
	Funeral Director		5. Social Security Number 579-22-6667	6. Sex 1 ☐ M 2 ∏ F	7. Age (In yrs. I		Months Days		Min	Date of Birth (Month, Day, 1) AY 14,	1925	Coun	lace (State o try) INGTOI	-
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation					11	0d. Inside C	ity Limits
I all y railed within 72 hours after death with the Maryland 2 should be filed within 72 hours after death with the Maryland and Mental Hyglene. Is marked other than "natural", or Itams 23s or 28s-f show reumatic event, II a Modical Examinar must be notified at		tor	MARYLAND MONTGO	MERY	SILV	ER SPF	RING						1 XYes	2□No
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leath w ns 23a		Funeral	3310 N. LEISURE	12. Was Dec	cedent Ever in U.		20906 Was Decedent of H If Yes, specify Cub	lispanic Origin	n? (Specify			ce - Americ		
000	be lied with 1/2 nours aller death with the Maryla tal Hygiens 1. Lal Hygiens and a the latter of tams 23a or 28a-1 shov a other than "natural", or Itams 23a or 28a-1 shov avant, II e Marylod Examiner or ust be notified at	by Fur	1 ☐ Never Married 2 ☐ Marr 3 ☑ Widowed 4 ☐ Divorced	If Yes G	2∭ No ive		if Yes, specify Cub 1 □ Yes 2 <mark>X</mark> No		Риепо ніса	an, etc.)	Specia	ck, White, o		
-002	2 nour	ted b	15. Deceden	t's Education		16a. Dece	dent's Usual Occup	pation	of working	11	6b. Kind of B			
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yland	Menta Menta arkad atic av	To B	MORRIS		TELSON			FANNI			MARL			
Mar	d 2 sho th and t7 is m traum		19a. Informant's Name/Relations MARILYN N. ELLI		ER		ng Address (Street WIGMORE							5
D D	ss 1 and of Health itam 27 othar tr		20a. Method of Disposition		20b. P	lace of Dispo	sition (Name of matory or other pla	1	Date		0c. Location			
	thent of the tant: If its tant: If its		1 X Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (S	ipecify)	JUD		MORIAL G		4/26/2	2005	OLNEY	, MAR	YLAND	
Dal	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic av 00.02.		21. Signature of Funeral Service	Licensee Stor	tlemy	RO RO	2. Name and Addre NZANSKY- OCKVILLE	GOLDBE	RG ME ROCKV	MORIAL ILLE, 1	CHAPE MARYLA	L INC	0852	
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and Death										tween	
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Spuc	w requires that been signed to should be det								- 1	1 💢 Yes	3 2 □ No	3 Prob	abiy 4 🗌	Unknown
ပ်	e taw has b je 2 st	ompleted								24a. Was an autopsy perform 1 Yes 2.	,	prior to cor death?	psy findings mpletion of a	available cause of
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_	is in	ToB	examiner? 1 ☐ Yes 2 【XNO		Inpatient 2		nt 3 DOA Ot	her: 4 Nurs		5 X Resider			r)	
u O	ding F th. : After e tunera	tlon	27. Manner of Death  1 XNatural 5 ☐ Pendir 2 ☐ Accident investi	ng (Mo	e of Injury onth, Day Year)	28b. Time o Injury	Wo	nyat ork? ]Yes 2∐No		28d. Describe how injury occurred				
JIVISION	To the Hospital or Attanding Pr within 24 hours atter death. To tha Funaral Director: After it completely tilled in by the tuneral	Certification:	3   Suicide 6   Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f.	28f. Location (Street and Number or Rural Route Number City or Town, State)			nber,		
_	spital		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
	the Ho nin 24 f tha Fu npletely	<b>dedical</b>	one)		basis of examina inner stated.	tion and/or in		opinion, death	n occurred a		te and place			s)
	With Con Con	Σ	29b. Signature and title of certified	sho			D479			2.5	1	25/05		
	10		30. Name and address of person	who completed car			Print)				200		min-	
			LILA M. BAHADO					SILVE	R SPR	RING, M	D 2090	)2		
	Sta Registi		31. Date filed (Month, Day, Year	9 2005	Registrar's Signa	J. A	perse							

Physician /Medical **Examiner** 

the Maryland

with

death

filed within 72 hours after

Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed or Attending Physician: after death, I Director: Af d in by the fur

Division of Vital Records, P.O. Box 68760,

Due to (or as a consequ	ence of):					
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Due to (or as a consequ	ence of):					
1 Live birth 2 Fetal	death 3 Ectopic			23d. Date of delivery Month Day Ye	ar	
ntributing to death but not resu	liting in the underlying	g cause given in Part I.				
JCTIVE LUNG	DISEASE		24a. Was an autopsy performed?	24b. Were autopsy findings av prior to completion of cau death? 1 □ Yes 2(X)No	raila ise r	
		26. Place of De	ath (Check only one)			
lospital: 1   Inpatient 2	ER/Outpatient 3	DOA Other: 4 XNursing	Home 5 Residence	6 ☐Other (Specify)		
28a. Date of Injury (Month, Day Year)						
28e. Place of Injury - At ho building, etc. (Specify	me, farm, street, fact )	28f. Location (Street a City or Town, Stat	18f. Location (Street and Number or Rural Route Number, City or Town, State)			
	1 DLive birth 2 Fetal 4 Pregnant at time of de 9 Unknown  htributing to death but not resu  UCTIVE LUNG  Hospital: 1 Inpatient 2 1 28a. Date of Injury (Month, Day Year)  28e. Place of Injury - At hobuilding, etc. (Specify	A Pregnant at time of death   S Other (   9 Unknown   Pregnant at time of death   S Other (   9 Unknown   Pregnant   Pr	1	Comparison of the content of the c	Comparison of the completion of cause of Death   Comparison of Compari	

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D28656

8609 Second Avenue #404B, Silver Spring, MD

29d. Date signed (Month, Day, Year)

April 28, 2005

within 24 hours a

+1

the

Medical

State Registrar

29b. Signaty

(Check only

31. Date filed (Mont

and title of certifier

Ravi Passi, M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

egistrar's Signature

		·	For State Registrar	State of Maryland /	Depa Ce	artment rtificate	of H	ealth a Death	and M		giene () (	)5	163	325	
	Physici	an	Decedent's Name (First, Middle, Last)							2. Date of Dea Month	Day	Year	3. Time o	f Death	
	/Medic		Dorothea Elizabet							April	26, 200	5	6:52	рм	
	Examin	er	4a. Facility Name (If not institution, give s 11621 New Hampshi		)	-		Location o			4c. County				
	Funeral		5. Social Security Number 6. Sex			If Under		er Sp	_	8. Date of Birt	Monto			or Foreian	
	Director			M 21□F 87	Yrs.	Months	Days	Hours	Min.	(Month, Day	y, Year)		hplace (State ountry)		
	yland		10a. State 10b. County	10c. City, To	wn or Lo	cation		_					10d. Inside C	ity Limits	
	e Maria	ctor	Maryland Montgo	mery	Silv	er Sp	ring	J					1 ☐ Yes	2 ☐ No	
	dith th	Dire	10e. Street and Number			10f. Zip	Code				10g. Citizen of W		untry?		
	sath v	erai	11621 New Hampsh			Man Doord	Uis	209		aifu Vaa as Na		JSA	door ladies		
39	be filed within 72 hours after death with the Maryland Hygiene. All Hygiene. do ther than "natural", or items 23a or 28a-f show do ther than "natural", or items 23a or 28a-f show evant, the Modical Examinar must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Midowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		If Yes, speci		Specify:	, Puerto f	cify Yes or No- Rican, etc.)	Specify:	k, White			
5-0036	2 hou atura		15. Decedent's Edu	eation 16	a. Dece	dent's Usual	Occupa	tion			16b, Kind of Bu	siness/	Industry		
2	within 7 iene. than "n he Medi	pie	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of worl DO NOT us	k done di e retired)	uring most	of workin	ig					
	filed wil Hygien other th ant, the	Completed		4	Tra	avel A		_			Trave				
and	be fil ntal H ad otf	Be	17. Father's Name (First, Middle, Last)								Maiden Sumame	∍)			
Maryland	ages 1 and 2 should be fi ant of Health and Mental H it: If Itam 27 is marked ot y ocether traumatic ever	2	Frederick Schuma  19a. Informant's Name/Relationship (Ty)		Ob Maili	na Addrana	(Street a			ea E. V		Canan 7	Tie Code)		
Ma	d 2 si th an t7 is r traur		Mary Theresa Osbou								or, City or Town, S				
	tam itam		20a. Method of Disposition	20b. Place	of Dispo	sition (Nam	e of			ate Ann	apolis, 20c. Location - (				
e E	Pages nent of int: Etc		1 ☐ Burial 2 ☐ Cremation 3 ☐ R  `4 ☐ Donation 5 ☐ Other (Specify)	amovai irom State	-	<i>natory or oti</i> Vationa:		-		ne 7,	Arlingto	'n	Virgin	io	
altimore,	permit. Page Department of Important: If any njury or once.		21. Signature of Funeral Service License	е	22	2. Name and	Address	s of Facility			Home I		ATIGIII	<u>Ia</u>	
ñ			James 5 Octo	كري							l ноте I ilver Sp		g, MD	20901	
Ĺ			23a. Part 1 Enter the disease, or compli shock, or heart failure. List only or	cations hat caused the death. Doe cause on each line.	o not ent	er the mode	of dying	, such as	cardiac oi	respiratory ar	rest,		Approximat Interval Bet	ween	
L	hysician		Immediate Cause (Final disease or condition	Ischemic Cere	brov	ascul	ar D	iseas	se			- 1	Onset and I		
H	/Medical Examiner		resulting in death)	Due to (or as a consequence	e of):							- 13			
		ner	If any, leading to inmediate	Congestive He		Failu	re					-	12 We	eks	
	nd nd transi	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events	Gastrointesti		Bleed	ing						4 Yea:	rs	
o,	be executed sician and burial-transit	EX	resulting in death) Last	Due to (or as a consequence	,										
9/80	physic	dical		_Alzheimer's D	emer	ıtia							7 Yea:	rs	
	ine death certificate b / the attending physic ched for use as the b	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	Bc. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 4 Pregnant at time of death 9 Unknown		Ectopic pre Other (spe					23d. Date Mon		*	Year	
S,	requires that the de een signed by the a nould be detached f	by	Part II. Other significant conditions con	tributing to death but not resulting	in the u	nderlying ca	use givei	n in Part I.			ebacco use contri				
ecord	w require	eted					-								
r ,	The la ate has page 2	Completed						-		24a. Was a autop. perfor	sy pr med? de	fere autrior to cleath?	topsy findings completion of c	available ause of	
VItal	Physicien: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:			Othou			(Check only or					
10 10	ding Phys h. After this funeral di	tion: To	27. Manner of Death  1.XX Natural 5 Pending	1   Inpatient 2   ER/C	Outpatier . Time of Injury	28	c. Injury Work'	at ?	2		ence 6 Othe ow injury occurre		sify)		
DIVISION	To the Hospitel or Attending within 24 hours after death.  To the Funaral Diractor: After completely filled in by the funer	2 Accident investigation M 1 Yes 2 No									28f. Location (Street and Number or Rural Route Number, City or Town, State)				
;	ne Hospit 124 hours ne Funara	edicai C	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examir	icien: To the best of my knowled er: On the basis of examination a and manner stated.	ge, deatl and/or in	n occurred a vestigation,	t the time in my opi	e, date and inion, deat	place, a	nd due to the o	cause(s) and man date and place, ar	ner as nd due	stated. to the cause(s	5)	
1	vithin To the compl	M	29b. Signature and little of certifier	44.0		29c.	License D	number 52247	7	2	29d. Date signed April 2				
	12		30. Name and address of person who co Collin D. Cullen			,	Δυρη	116 +	±101	Betha	sda, MD	200	1.4		
F	Sta Registra	_	31. Date filed (Month, Day, Year)  APR 2 9 200	32 Registrar's Signature			. IV CII	ac, f	, 101,	necues	sua, MD	208	14		

		•	For State Registrar	State of Maryland / Dep	partment of Health and I		giene Reg. No.2. 0 0 5	16326
	Physici		1. Decedent's Name (First, Middle, La	ast)		2. Date of Dea Month	ath Day Year	3. Time of Death
	/Medic Examin		CAROLYN REBECC.  4a. Facility Name (If not institution, given		4b. City, Town, or Location of Death	APRIL	13, 2005 4c. County of Death	
	Funeral Director			HOSPITAL CENTER Sex 7. Age (In yrs. last birthday 1□ M XXF Yrs.	CHEVERLY  If Under 1 Year   If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day	v, Year) Cou	GEORGES  uplace (State or Foreign Intry)  SHINGTON, DO
	/land		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or L	ocation	NOV. 23		10d. Inside City Limits
	h the Mar r 28e-f si s notified	Director	MARYLAND PRINCE  10e. Street and Number	GEORGES LANHAM	10f. Zip Code		10g. Citizen of What Cou	XXYes 2 □ No untry?
	3a o		6812 97TH PLACE		20706		UNITED STA	TFC
36	within 72 hours after death with the Maryland jiene. r then "natural", or Items 23a or 28e-f show the Madical Examinan must be notified at	y Funerai	11. Marital Status 1 □ Never Married ※※ Married	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ※XXNo If Yes, Give	Was Decedent of Hispanic Origin? (Spirit Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)		ican Indian, , etc.
21215-0036	72 hours "natural",	leted by	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's E (Specify only highest gr	Year or Dates:  Education 16a. Dece ade completed) (Giv.	edent's Usual Occupation e kind of work done during most of work	king	16b. Kind of Business/Ir	
12121	filed within Hygiene.	Completed	Elementary/Secondary (0-12) 11TH  17. Father's Name (First, Middle, Lass	College (1-4or 5+) BU	DO NOT use retired)  IDGET ANALYST	. (First Adjudge	FEDERAL G	OVERNMENT
Maryland	ev d	To Be	FRANKLIN RATCLIF	F, SR.	MARY G	ADDY	Maiden Sumame)	1
a	2 st and reun	16 8	19a. Informant's Name/Relationship	(Type, Print) 19b. Mail	ling Address (Street and Number or Ru	rai Houte Numbe	r, City or Town, State, Zij	p Code)
	Pages 1 and 2 shoutd nent of Health and Mer int: If item 27 Is marke iry or other treumelic	1 2	20a. Method of Disposition  XX Burial 2 ☐ Cremation 3 [	20b. Place of Disp cemetery, cre	position (Name of matory or other place)	NHAM, MD	20c. Location - City or To	***************************************
Baltimore,	permit. Page Department of Importent: If eny injury or once.		*4 □ Donation 5 □ Other (Special Service Lices)	nsee 2	MEMORIAL PARK 04/1 22. Name and Address of Facility IARSHALL'S FUNERAL	HOME OF	LANDOVER, MARYLAND, I	NC.
			23a Part Enter the disease or con	nplications that caused the death. Do not er	308 SUITLAND ROAD		AND, MD 207	4.6 Approximate
	Pnysician /Medical		shock or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line.  a. SEPTICEMIA  Due to (or as a consequence of):	nor the mede of dying, each as saidings	or respiratory arr		Interval Between Onset and Death
	Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. SHOCK Due to (or as a consequence of):				
,0	cate be executed physicien and the burial-transit	Examin	that initiated events resulting in death) Last	c. CHRONIC RENAL FA	ILURE			1
8760,	cate b	dical		d.				
.O. Box 6	he death certificate the attending phys thed for use as the	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes XXNo 9  Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of delive	rery Day Year
<u>α</u>	requires that the d een signed by the hould be detached	by	Part II. Other significant conditions	contributing to death but not resulting in the	underlying cause given in Part I.		bacco use contribute to t	
Vital Records,	e law has b je 2 sl	Completed				24a. Was a autop: perfor	sv prior to co	opsy findings available ompletion of cause of
12	iiclen: Th certificate rector, pag	Be	25. Was case referred to medical		26. Place of Dea			
<b>&gt;</b>	× 5 =	2	examiner? 1 □ Yes XX No	Hospital: XX Inpatient 2 ☐ ER/Outpatie	ent 3 DOA Other: 4 Nursing H	ome 5 Resid	ence 6 □Other (Specit	fy)
Division of	Attending Ph r death. ector: After th by the funeral		27. Manner of Death  XXNatural 5 Pending 2 Accident investigation		of 28c. Injury at Work?  M 1 Yes 2 No	28d. Describe hi	ow injury occurred	
DIX	tel or Attendin rs after death. el Director: Afi ed in by the fur	Certification:	3 ☐ Suicide 6 ☐ Could not to determined	28e. Place of Injury - At home, farm, si building, etc. (Specify)	treet, factory, office	28f. Location (S. City or Tow.	treet and Number or Rura n, State)	al Route Number,
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edical	(Check only 2 Medical Exa	hysician: To the best of my knowledge, dea miner: On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occur	and due to the c red at the time, d	ause(s) and manner as s late and place, and due to	itated. o the cause(s)
)	To the within To the comple	Σ	29b. Signature and title of certifier	Valles	29c. License number		APRIL Z9,	
C	(10)		30. Name and Address of person who HECTOR COLLISO	1	O1 COLESVILLE RD.	#310 SI	LVER SPRING	, MD 20910
	Sta Registr	4.7	31. Date filed (Month, Day, Year)  MAY 0 2 2005	32. Registrar's Signature				

State of Maryland / Department of Health and Mental Hygiene

Physician /Medical	Decedent's Name (First, Middle, Las.	t)	Ce	rtificate o	Death	2. Date of Deel	eg. No. 2	0 5 3. Time of			
. /Modical		ert				Month		Year			
	4a Facility Name (If not institution, give				4b. City, Town, or I		23, 20 4c. County of	02			
Examiner					Williams			ngton			
	Williamsport Nurs  5. Social Security Number 6. Se		rs. last birthday)	If Under 1 Yea							
Funeral Director	190-10-8531	7 4 6 KW =	3 Yrs.	Months Day	s Hours Min.	8. Date of Birth (Month, Day, March 1	, 1912 W	9. Birthplace (State of Country) lest Virgin			
within 72 hours eftar daath with tha Manyland ana. than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at ompleted by Funeral Director	Usual Residence of Decedent  10a. State 10b. County	10c. (	City, Town or Lo	cation		virt		10d. Inside Ci			
eftar death with the Marylar or Nems 23a or 28a-f show miner must be notified at Funeral Director	Maryland Washingt	on W	illiams	ort				1 ⊠ Yes			
res ries	10e. Street and Number			10f. Zip Code	)	1	0g. Citizen of W	hat Country?			
3a o ie	154 North Artizan	St.		21	795		USA				
ifier death with the Me r items 23a or 28a-1 s inner must be notified Funeral Director	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U,S. 13.	Was Decedent o	f Hispanic Origin? (S uban, Mexican, Puert	pecify Yes or No-		- American Indian,			
pamit. Pegas 1 and 2 should be filad within 72 hours eftar Bepertmant of Haalth and Mantal Hygiana.  mportant: if Item 27 is marked other than "natural", or ite nst injury or other traumatic event, the Modical Examine 20ca.  To Be Completed by Fur	1 Never Married 2 Married	1 ☐ Yes 2 No				o Rican, etc.)		, White, etc.			
ours e	3X Widowed 4 ☐ Divorced	1 ☐ Yes 2 No If Yes, Give Year or Dates:		1□Yes 21X N	o Specify:		Specify:	White			
lad within 72 hours ygiana. "natural", wr than "natural", nt. the Modical Exu Completed by	15. Decedent's Edu (Specify only highest grad	ucation	16a. Dece	dent's Usual Occ	upetion	kina	16b. Kind of Bus	siness/Industry			
hin 7	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use reti	e during most of wor red)	Killy					
d wit	12		House	ewife		PARAMA	Home				
be file d oth event	17. Father's Name (First, Middle, Last)				18. Mother's Nan	ne (First, Middle, M	Maiden Surname	)			
Mante Marked	William	Burkett			Hettie		Shotts				
sho and h and h	19a. Informant's Name/Relationship (T	ype, Print)	19b. Maili	ng Address (Stre	et and Number or Ru	ral Route Number	, City or Town, S	State, Zip Code)			
and 2 alth 27 is	Donald J. Pert - S			uckingha		hoboth B	each,DE	19971			
other	20a. Method of Disposition	20b	. Place of Dispo	sition (Name of natory or other p	lace)	Date	20c. Location - C	ity or Town, State			
Pega ant c nt: if	1 N Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	Hemoval from State	_	d Mem. P	1	4-26-05	ower Bu	rrell,PA			
mit. Sertm Sorta	21. Signature of Fyneral Service License			. Name and Add	4	orne Fur					
parmit. Pegas 1 and 2 should be filad within 72 hours Daperman! of Haalth and Mantal Hygiana. Important: if Item 27 is marked other than "natural; any Injury or other traumatic event, the Medical Exponse.  To Be Completed by	1 11	Odi			USI						
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hearffailure. List only one cause on each line.  425 S.Conococheague St. Williamsport, MD 21795  Approximate Interval Between										
Dhuninian	shock, or heart failure. List only o	ne cause on each line.			,,		,	Interval Bet Onset and I			
Physician /Medical	Immediate Cause (Final				1						
Examiner	disease or condition resulting in deeth)	a Gangrer Due to b. Atherosc	re of	The los	ver ext	remitie	<u>.</u>	1 weel			
<b>6</b>		A . /	(or as a consec	juence or):				12/			
ficete be axecuted the physicien and its the bunal-transit edical Examiner			(or as a consec		210Vasa	llar V	sease	year			
axecuted on end hal-transit Examir	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Duc to	(01 43 4 0011300	do:100 01/.				1			
e be sicie a bur		C. Due to	(or as a conseq	lience of):							
rificete be axecuted ng physicien end tas the burial-transit Medical Examir	resulting in death) Last	<i>Date</i> to	(01 43 4 0011304	derioe 01).							
r cartinular and		d									
d for icia	Part II. Other significant conditions co	ntributing to death but not re	esulting in the u	nderlying cause	riven in Part I	23b. Did to	bacco use conf	ribute to the cause of			
tha oy the eche	Tarri. Other significant conditions co.	thibuting to doubt but not to	osalling in the a	idonying cadso ;	givori ir vait i.	1 □ Y	/	3 ☐ Probably 4 ☐			
thet nad t	Parkinson's Dis	sease					55 2 2 110				
Tha law raquires thet tha death cacate hes baan signed by the attandit page 2 should be deteched for use Completed by Physician/						24a. Was a	n autopsy	24b. Were autopsy f			
v rac baa shor	Ostroarthriti	S				perform	ned?	available prior to completion of c of death?			
a hes	7	7 N 1 1 2	, 7	255		1U Ye	2 2 No	1 □ Yes 2 □			
F # B O	25. Was case referred to medical	the Hizheim	iers 1	ype_	00 Plans ( Das			TLL Yes 2L			
E 5 6	examiner?	Hospital: 1 ☐ Inpatient 2	CI ED/Outpation	+ 3□ DOA		th <i>(Check only on</i> ome 5 ☐ Reside		(Canada)			
cartificata iractor, pag	27. Manney of Death			28c. In		28d. Describe ho					
Physician: rthis cartific iral diractor.		28a. Date of Injury (Month, Day Year)	Injury		'ork? □Yes 2□No						
ding Physician: h. Aftar this cartific funaral diractor, tion: To Be	1 Natural 5 Pending			(		28f. Location (St.	reet and Numbe	r or Pura I Pouto Num			
trending Physician: daath. ctor: Aftar this cartific y the funaral diractor, fication: To Be	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At	home, farm, str	BOL TACIOTY, OTHIC				or nural noute reulli			
ng Physician: Afar this cartifu unaral diractor	2 ☐ Accident investigation	28e. Place of Injury - At building, etc. (Spec	home, farm, str cify)	eet, ractory, ome	6	City or Town	n, State)	OF HUIST HOUSE NUM			
lospital or Attending Physician: 4 hours efter death. 'uneral Director: After this cartificaty filled in by the funaral director. cal Certification: To Be	2 Accident investigation 3 Suicide 6 Could not be determined	building, etc. (Spec sician: To the best of my kr	cify) nowledge, death	occurred at the	time, date and plece,	City or Town	n, State) ause(s) and man	ner es stated.			
the Hospital or Attending Physician: hin 24 hours efter death. the Funeral Director: After this cardification npletaly filled in by the funeral director.	2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)    Condition investigation investigation of the determined	building, etc. (Spec	cify) nowledge, death	occurred at the restigation, in my	time, date and plece, opinion, death occur	City or Town	ause(s) and man ause and place, ar	ner es stated. nd due to the cause(s			
To the Hospital or Attending Physician: Tha I within 24 hours effer death.  To the Funeral Director: Affar this cartificate he completely filled in by the funeral director, page Medical Certification: To Be Com	2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)  29b. Signature and title of certifier	building, etc. (Special Special Specia	nowledge, death	o occurred at the vestigation, in my 29c. Lice	time, date and plece,	and due to the cared at the time, da	ause(s) and man ate and place, ar	ner es stated. nd due to the cause(s			
To the Hospital or Attending Physician: within 24 hours efter death.  To the Funeral Director: After this cartific completaly filled in by the funeral director.  Medical Certification: To Be	2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)  29b. Signature and title of certifier	building, etc. (Special sician: To the best of my known of the basis of examination of the basis of th	nowledge, death	o occurred at the vestigation, in my 29c. Lice	time, date and plece, opinion, death occur	and due to the carred at the time, da	ause(s) and man ate and place, ar	ner es stated. Indicate de la cause (s  (Month, Day, Year)			
To the Hospital or Attending Physician: Tha law raquires that tha death car within 24 hours effer death.  To the Funeral Director: Attar this cartificata has baan signad by the attandin completaly filled in by the funaral diractor, page 2 should be datached for usa Medical Certification: To Be Completed by Physician/N	2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)  29b. Signature and title of certifier	building, etc. (Special Section 1) building, etc. (Special Section 1) building and manner stated.	nowledge, death	o occurred at the vestigation, in my 29c. Lice	time, date and plece, opinion, death occur	and due to the carred at the time, da	ause(s) and man ate and place, ar	ner es stated. nd due to the cause(s			

DHMH 16 Rev 6/95

05-2713

MELVIN M. POWELL Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For tate Unpend Item 23a&27 per me G843 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Time of Death 2005 **Physician** MELVIN M. POWELL APRIL 18, 0252 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PRINCE GEORGES HOSPITAL CHEVERLY PRINCE GEORGES 8. Date of Birth (Month, Day, Year) June 20, 1 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days Hours 1 XM 2 ☐ F 54 Yrs. 578-66-3426 1950 Washington, Usual Residence of Decedent

10f. Zip Code

1 ☐ Yes 2 X No

20743

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Specify:

10d. Inside City Limits 1 X Yes 2 No

10g. Citizen of What Country?

United States

111 Penn Street Baltimore, Maryland 21201

14. Race - American Indian, Black, White, etc.

Specify: Black

10c. City, Town or Location

Capitol Heights

Funeral Director

10a. State

Maryland

11. Marital Status

10e. Street and Number

7230 G Street

1 Never Married 2 Married

3 Widowed 4 Divorced

Director

Funeral

þ

10b. County

Prince Georges

ZGreenberg

31. Date filed (Month, Day, Year) APR 2 9

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Year or Dates:

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or items 23e or 28e-f show any injury or other treumatic avent, if e Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Physician /Medical **Examiner** 

burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, as the t attending p ned by the a within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral of

etec	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a. Decedent's Usual Occupation (Give kind of work done durin life. DO NOT use retired)	g most of working	16b. Kind of Business	/Industry
To Be Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Electrical Tech		PEPCO	
Ö	17. Father's Name (First, Middle, Last)		<u>'                                    </u>	Mother's Name (First, Middle		
0 8	William Henry Po	well		Marian D. Cra	wford	
_	19a. Informant's Name/Relationship (T		19b. Mailing Address (Street and I	Number or Rural Route Num	ber, City or Town, State,	Zip Code)
	Lavida A. Powell	(wife)	7230 G Street,	Capitol Heigh	ts, MD 207	43
	20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 🖔  4 □ Donation 5 □ Other (Specify	Removal from State	Place of Disposition (Name of semetery, crematory or other place) Lleville Cemetery	Date 5/4/05	20c. Location - City or Suffolk, V	
	21. Signature of Foneral Service Licens			Facility McGuire F	uneral Serv	ice
	Lindro 2	horsen		a Ave. N.W.,		
	23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final	one cause on each line.			arrest,	Approximate Interval Between Onset and Death
	disease or condition resulting in death)	a. Complication  Due to (or as a conseq	s of intraabdomir	al tumor		·
			donos or).			
iner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	Due to (or as a conseq	uence of):			
cam	Cause (Disease or injury that initiated events resulting in death) Last	c				
a E	rooting in south, cast	Due to (or as a conseq	uence of):			
adlc		d				
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	I death 3 ☐ Ectopic pregnancy		23d. Date of de Month	livery Day Year
H.	Part II. Other significant conditions co	ntributing to death but not res	ulting in the underlying cause given in	Part I. 23e. Did	tobacco use contribute to	the cause of death?
ed b				1	Yes 2 □ No 3 □ Pr	obably 4 Unknown
Complet				24a. Wa auto peri 1 1 Yes	s an 24b. Were au prior to ormed? death? 2 \( \triangle	utopsy findings available completion of cause of 2 \square No
Be (	25. Was case referred to medical examiner?			Place of Death (Check only		
	1 XYes 2 □ No		ER/Outpatient 3X DOA Other: 4	☐ Nursing Home 5☐ Res	idence 6 Other (Spe	cify)
atlon:	27. Manner of Death 1. Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury at Work?  M 1 Yes	28d. Describe	how injury occurred	
Certific	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, street, factory, office	28f. Location City or To	(Street and Number or Ru wn, State)	ural Route Number,
Medical Certification: To	29a. Certifier 1 ☐ Certifying Phy (Check only one) 2 ☑ Medicel Exam	vsician: To the best of my kno iner: On the basis of examina and manner stated.	wledge, death occurred at the time, dation and/or investigation, in my opinion	ite and place, and due to the i, death occurred at the time	cause(s) and manner as date and place, and due	stated. to the cause(s)
M	29b. Signature and title of certifier  Jordan	heerberg 1	29c. License nur OCME	nber	APRIL 20	h. Day, Year) , 2005
	30 Name and address of person who co	ompleted cause of death (Item	23a) (Tuno Brint)			

State Registrar

			1 - State Registrer	State of Maryland			of Health		ı	Reg. No. 20	05 16320
	Physici	an.	Decedent's Name (First, Middle, Last)						<ol><li>Date of Dea Month</li></ol>	Day Y	3. Time of Death
	/Medio		Helen DeShont		Poole	<del> </del>			April 2	6, 2005	9:45 P M
	Examir	ıer	4a. Facility Name (If not institution, give str	eet and number)		-	own, or Location			4c. County of	Death
			4701 Oxbow Road				Rockvil				tgomery
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last	birthday) Yrs.	If Under 1 Months	Days Hours		8. Date of Birt (Month, Day	h y, Year) 9.	Birthplace (State or Foreign Country)
	Director		578-12-1025	90	115.				Sept. 1	1, 1914 V	Washington, DC
	and w		10a. State 10b. County	10c. City, To	own or Lo	cation					10d. Inside City Limits
	/anyl	5	Marana and				-1. 133				1 ☐ Yes 2 ☐XNo
	28a-	ect	Maryland Mc  10e. Street and Number	ontgomery		10f. Zip C	ckville			10g. Citizen of Wha	at Country?
	with	ā	4701 Oxbow Road				0852			USA	
	72 hours after death with the Maryland natural, or Itams 23a or 28a-f show cleaf Examilier o ust be putified at	Funeral Director		. Was Decedent Ever in U.S.	13 \			Origin? (Spe	or No.		American Indian,
	Itan Itan	ä	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🔀 No	10.1	f Yes, specif	y Cuban, Mexic	an, Puerto	ecify Yes or No- Rican, etc.)	Black, V	White, etc.
336	irs at		3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		∏Yes 2	X No Specif	fy:		Specify: V	Vhite
21215-0036	2 hou	Completed by	15. Decedent's Educa		6a. Deced	lent's Usual	Occupation			16b. Kind of Busin	ness/Industry
15	-	pie	(Specify only highest grade of Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give life. L	kind of work OO NOT use	done during m retired)	ost of worki	ng		·
212	yiene r the	E	12	College (1-401 5+)	Adm	inist	rative	Assis	tant	Departmen	nt of Defense
g	be filad within 72 hours after death with the Marylan Ital Hygiene. Id other than "natural", or Itams 23a or 28a-f show event, I've Medical Examilher outst be puilled at	Be	17. Father's Name (First, Middle, Last)							Maiden Sumame)	
<u>a</u>	ould be Mental arkad o	TOE	Benjamin F. Petti	.S			Gr	ace C	atherin	e Brosnah	nan
Maryland	should and Men s marks umatic	-	19a. Informant's Name/Relationship (Type	, Print)	19b. Mailin	g Address (	Street and Num	ber or Rura	l Route Numbe	r, City or Town, Sta	ate, Zip Code)
	and 2 ealth a n 27 lg		Donna M. Poole/ D	aughter	1591	5 Ave	ry Road	, Der	wood, M	aryland 2	20855
Je,	tem of He		20a. Method of Disposition		e of Dispo	sition (Name	of er place)		ate	20c. Location - Cit	y or Town, State
E	Pages nent of int: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ Rer `4 ☐ Donation 5 ☐ Other (Specify)	noval from State		ven Cem		April 20		Silver S	ring, Marylan
Baltimore,	그 든 뿐 글		21. Signature of Funeral Service Licensee		22	. Name and	Address of Fac			Home Inc	
m	permi Depar Impor any ir		Janes & Oct	Lu .	50	O Univ	versity	Blvd	. W. Si	Home Inc lver Spri	ng,MD 20901
			23a. Part1. Enter the disease, or complica	itions that caused the death. [		-					Approximate
	Pnysician		shock, or heart failure. List only one Immediate Cause (Final		17 T.,						Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Non-Small Cel		ng car	rcinoma				15 Months
	Examiner				,-						
		je.	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequent	ce of).						
	uted	Ē	Cause (Disease or injury that initiated events								
o,	be axecuted sician and burial-transit	Examiner	resulting in death) Last	Due to (or as a consequence	ce of):			-			
8760,	death certificate be axecuted e attending physician and nd for use as the burial-transit	Physician/Medical	d.								
9	tifica g ph as th	ledi	7.							-	
Вох	eath certific attending p for use as f	N/u	IF FEMALE: 23b. Was decedent pregnant 23c	t. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea		Ectopic pred				23d. Date of	f delivery
	deat e atte	icia	in the past 12 months? 1 □ Yes 2 □ No	4☐Pregnant at time of death		Other (spec				Month	Day Year
P.0	t the de by the a	hys	9 🗆 Unknown	9□ Unknown							
	Tha taw requires that the tte bas bean signed by the bage 2 should be detache	by P	Part II. Other significant conditions contr				-			bacco use contribu	te to the cause of death?
ğ	w require basn sig should b		Ishemic Cardiomyop	athy, Chronic	Obstr	uctive	Lung	Diseas	39, 12□Y	es 2⊡No 3□	Probably 4 Unknown
Records,	aw re	Completed	Lupus Anticoagulan	t Antibody					24a. Was a	an 24b. Wer	e autopsy findings available
Ä	That ate ha	Eo							autop: perfor	med? deat	r to completion of cause of th? Yes 2□ No
Vital		Φ	25. Was case referred to medical				26. Pla	ce of Death	(Check only or		16\$ 2   140
>	Physician: this certific ral director,	.0 B	examiner? 1 Yes 2 No	spital:	Outpatien	t 3 DOA	Other			ence 6 Other (	Specify)
of	g Ph er th	n: T	27. Manner of Death		b. Time of		. Injury at Work?			ow injury occurred	opeony)
Ö	Attending r death. ector: After by the funer	atio	1 ☑ Matural 5 ☐ Pending 2 ☐ Accident investigation	(WORTH, Day 16ar)	Injury	M	1 ☐ Yes 2	□No			
Division	I or Attencater death Director:	ific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home	, farm, stre	eet, factory, o	office	2	28f. Location (S City or Tow	treet and Number o	or Rural Route Number,
	al or A s after il Dire	Certification;	4 1 Hornicae	building, etc. (Specify)					City of Yow	n, State)	
	Hospital 24 hours a Funeral I		29a. Certifier 1 CCertifying Physic	cian: To the best of my knowled	dge, death	occurred at	the time, date	and place, a	and due to the d	ause(s) and manne	er as stated.
	To the Hospital or within 24 hours after To the Funeral Director completely filled in the Funeral or the Funeral Director filled in the funeral or the funeral or the funeral filled in the funeral filled filled in the funeral filled	edicai	(Check only 2 Medical Examine one)	r: On the basis of examination and manner stated.	and/or inv	estigation, ir	n my opinion, de	eath occurre	ed at the time, o	ate and place, and	due to the cause(s)
	To the within 2 To the complet	Ň	29b. Signature and title of certifier	2.4		29c. I	License numbe	r	2	29d. Date signed (N	fonth, Day, Year)
)			Midwel a. W	1. D.	•		D52451		i	April 28,	2005
	20		30. Name and address of person who com	pleted cause of death (Item 23	a) (Type,	Print)					
			Michael A. Westerm		0 01	d Geor	getown	Road,	Bethes	sda, MD 2	0814
ė	Sta		31. Date filed (Month, Day, Year)	32. Segistrar's Signature	- 1	act o					
	Registi	ar	APR 2 9 200	13 DEMENS DE	1	Contract of the Party of the Pa					

			a POI	artment of Health and Me	ental Hygie	6000	16330
	Physicia		1. Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
ı	/Medic	al	Anne Augustine Palasky		April 24		3:30 p <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, give street and number) Holy Cross Hospital	4b. City, Town, or Location of Death Silver Spring		4c. County of Dea Montgon	
	Funeral		Social Security Number 6. Sex 7. Age (In yrs. last birthda)	) If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	9. Birt	thplace (State or Foreign
	Director		183-18-4401 1□M 2\(\text{\text{M}}\)F 82 Yrs.	Months Days Hours Min.	(Month, Day, Ye July 25,	1922 Pe	nnsylvania
	land		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or I	ocation			10d. Inside City Limits
	Mary B-f sh	tor	Maryland Montgomery S	ilver Spring			1 ☐ Yes 2 🖰 No
	or 284	Direc	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Co	-
	sath w	Funeral Directo	12911 Neola Road  11 Marital Status 12. Was Decedent Ever in U.S. 13	20906	oify Vas or No.	USA	
38	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "natural", or thems 23a or 28a-f show aumatic avant, the Modical Execution in at the notified at	by Fune	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 □ No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Specify Yes, specify Cuban, Mexican, Puerto F	Rican, etc.)	Black, Whit	
2-0	72 hou	eted	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	edent's Usual Occupation a kind of work done during most of workin	16b	. Kind of Business	/Industry
2	within ne.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)		~	
2	filed v Hygie othar t	CO	12 17. Father's Name (First, Middle, Last)	Office Worker 18. Mother's Name		Governmen den Sumame)	ıt
<u>lan</u>	m - 0 2	To Be	Miklos Augustin	Katal	in Sbul		
Maryland 21215-0036	permit. Pages 1 and 2 should be Department of Health and Menta Important: If itam 27 is marked any injury oc other traumatic avonce.			ing Address (Street and Number or Rural 11 Neola Road, Silv			
altimore,	of Hea of Hea of Hea of Hea of Hea		20a. Method of Disposition  20b. Place of Disposition  1 △ Burial 2 ☐ Cremation 3 ☐ Removal from State	osition (Name of practory or other place) May	ate 20c	. Location - City or	Town, State
Ĕ	Pages Iment of I		`4 □Donation 5 □Other (Specify)	an's Cemetery 20	05 Cr		, Maryland
Bai	permit. Departr Imports any inje			2 Name and Address of Facility Francis J. Collins 500 University Blvd			g, MD 20901
			23a. Part1 Enter the disease, or complications has caused the death. Do not e shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac or	r respiratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. Sepsis				Days
١	Examiner		Due to (or as a consequence of):  Pneumonia				Days
	p .∺	ner	Sequentially list conditions, the sequential process of the sequence of the se				
	ecute and I-trans	Examiner	Cause (Disease or injury that intitated events resulting in death) Last c.  Due to (or as a consequence of):				
8760,	cate be executed oblysician and the burial-transit	dical E	d			- 1	
9	tificate ng phy as the	ledic					
Box	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burral-transit	Physiclan/Me		□Ectopic pregnancy		23d. Date of de	livery Day Year
o.	he dea the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown  4 ☐ Pregnant at time of death 5	Other (specify)			,
٦.	res that the de signed by the a l be detached f	by Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	co use contribute to	the cause of death?
rds	w requires been sign should be	ed b	Atrial Fibrillation		1 🗆 Yes	2 □ No 3 □ Pr	obabiy 4 🛣 Unknown
Vital Records,	law re as be	Completed			24a. Was an autopsy	prior to	utopsy findings available completion of cause of
<u>=</u>	(0				performed		2 🗆 No
	Physician: r this certificatal director,	Be c	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ KNo  Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpati	26. Place of Death Other: 4 A Nursing Hom	(Check only one) ne 5 ☐ Residence	S DOther (See	-:4.1
1 0	Phy this ral o	n: To	27. Manner of Death 28a. Date of Injury 28b. Time		28d. Describe how in		City)
Sior	Attanding F r death. actor: After by the funer	atio	2 Accident investigation	M 1 Yes 2 No			
Division of	l or Attano after death Diractor: I in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Street City or Town, St		ural Route Number,
	Hospital 24 hours Funaral tely filled		29a. Certifier 1 Certifying Physicien: To the best of my knowledge, dea				
	H 24 H	ledical	(Check only 2 Medicel Exeminer: On the basis of examination and/or one) and manner stated.				
	To the within 3	Σ	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Mont	n, Day, Year)
	2		30. Name and address of person who completed cause of death (Item 23a) (Typi	D32332	F	April 24,	2005
			Suresh K. Gupta, M.D. 9801 Goergi	a Avenue, #220, Sil	ver Sprin	ng,MD 209	02
	Sta Registr		31. Date filed (Month, Day, Year)  APR 2 9 2005  32 Registrar's Signature	arti			
		-				-	

_	·	1 - For State Registrar	State of Maryla	and / Department of Health and Certificate of Death		ene g. No. 2005 1633
Physicia	an	Decedent's Name (First, Middle, L.	ast)		Date of Death     Month	Day Year 3. Time of Death
/Medic		GILES 4a. Facility Name (If not institution, g	ive street and number)	RTCHMOND JR.  4b. City, Town, or Location of De	APRIL.	21 2005 9:40 P 4c. County of Death
Funeral Director		5. Social Security Number 6. 238–46–2767 Usual Residence of Decedent		s. last birthday) Yrs.  CLINTON  If Under 1 Year If Under 24 H  Months Days Hours M	8. Date of Birth (Month, Day,  May 15 1	PRINCE GEORGE'S  9. Birthplace (State or For Country)  North Carolin
how	_	10a. State 10b. County	10c. (	City, Town or Location		10d. Inside City Lin
or 28a-f show	Funeral Director		George's	Bowie		1 <b>X</b> Yes 2 □
Se or 3	IDI	10e. Street and Number 12435 Melling La	ne	10f. Zip Code 20715	10	g. Citizen of What Country? U.S.A.
ems 2	nera	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	(Specify Yes or No-	14. Race - American Indian,
f Health and Mental Hygiene. Item 27 te marked other than "natural", or Items 23e or 28e-f show other traumatic svent, the Mudical Examiner must be notified at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 <b>X</b> No If Yes, Give Year or Dates:	1 ☐ Yes 2 🔀 No Specify:	ento Alcan, etc.)	Specify: Black
"nati	Completed	15. Decedent's (Specify only highest g	rade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of v life. DO NOT use retired)	vorking	6b. Kind of Business/Industry
and Mental Hygiene. ta marked other than ". aumatic svent, II e M.	ome	Elementary/Secondary (0-12) 8th	College (1-4or 5+)	Cab Driver		Private
ital Hygir d other svent, II	Be C	17. Father's Name (First, Middle, Las			lame (First, Middle, Ma	
nd Ment marked umatic s	10	Giles C. Richmo			n Bayne	
th and 7 ta m traum		19a. Informant's Name/Relationship		19b. Mailing Address (Street and Number or 12435 Melling Lane B		
of Health item 27 I		20a. Method of Disposition	<del>-</del>	Place of Disposition (Name of cemetery, crematory or other place)		Oc. Location - City or Town, State
		1 🛣 Burial 2 ☐ Cremation 3  '4 ☐ Donation 5 ☐ Other (Spec	Tremoval mom State	t. Lincoln Cemetery Apr		rentwood, Maryland
Department of Important: If any injury or once.		21. Sign turn of Funeral Servic Lic		22. Name and Address of Facility		kins Funeral Home
9 = 9		8	-	7474 Landover Roa	d Landover	, Maryland 20785
nysician Medical Medical the prizat-transit	sal Examiner	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	Renal Failure equence of):		
e attending p d for use as	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of preg 1   Live birth 2   Fe 4   Pregnant at time of 9   Unknown	tal death 3 Ectopic pregnancy		23d. Date of delivery Month Day Year
es that the digned by the		Part II. Other significant conditions	contributing to death but not re	esulting in the underlying cause given in Part I.		cco use contribute to the cause of death
cate has been si page 2 should l	Completed				24a. Was an autopsy performe	
certificate rector, pag	Be (	25. Was case referred to medical examiner?		26. Place of D	eath (Check only one)	A
After this uneral di	P	1 Tyes 2 No  27. Manner of Death  1 XNatural 5 Pending	Hospital: 1 Inpatient 2 2 28a. Date of Injury (Month, Day Year)	□ ER/Outpatient 3 □ DOA Other: 4 1 ○ Nursing 28b. Time of Injury M Work?  M 1 □ Yes 2 □ No	Home 5 Residence 28d. Describe how	ce 6 Other (Specify) injury occurred
after deat Director: I in by the	Certification;	2 Accident investigati 3 Suicide 6 Could not 4 Homicide determine	be Ose Blees of Initial At	home, farm, street, factory, office	28f. Location (Stree City or Town,	et and Number or Rural Route Number, State)
Fur ely	edical	29a. Certifier 1  Certifying F (Check only one) 2  Medical Exe	Physician: To the best of my kr iminer: On the basis of examin and manner stated.	nowledge, death occurred at the time, date and pla nation and/or investigation, in my opinion, death oc	ce, and due to the causeured at the time, date	se(s) and manner as stated. e and place, and due to the cause(s)
within 2  To the complet	Σ	29b. Signature and title of centrier	3	29c. License number	29d	. Date signed (Month, Day, Year)
7	11	1/0/	M	D24535	Ap	oril 28 2005
1 6		30. Name and address of person who	completed cause of death (Ite	em 23a) (Type, Print)	12,147	
(8 )		Laxmi Berwa M.	D 7700 011 -	Branch Avenue Clinton,		20735

#### Ple

1. Decedent's Name (First, Middle, Last)  RUTH MILDRED RULEY  4a Fecility Neme (If not institution, give street end number)  FUTURECARE PINEVIEW  5. Sociel Security Number  6. Sex 1	Dey Year 27 2005 8:10 Pl  4c. County of Deeth  PRINCE George'S  9. Birtholece (State or Foreign)			
1. Decedent's Name (First, Middle, Last)  RUTH MILDRED RULEY  4a Fecility Neme (If not institution, give street end number)  FUTURECARE PINEVIEW  5. Sociel Security Number  6. Sex 1	Dey Year 3. Time of Death 27 2005 8:10 Pl  4c. County of Deeth PRINCE George'S  Yeer) 9. Birthplece (State or Foreit Country) 1924 Virginia  10d. Inside City Limit Yard Yes 2 December 1000 No.			
RUTH MILDRED RULEY  4a Fecility Neme (If not institution, give street end number)  FUTURECARE PINEVIEW  5. Sociel Security Number  6. Sex 1 M 2 F 80 Yrs.  CLINTON  6. Sex Yrs.  Months Days Hours Min.  Sept. 5  Usuel Residence of Decedent  10a. Stete 10b. County  Maryland Prince George's  Clinton  10f. Zip Code  APRIL  4b. City, Town, or Location of Deeth CLINTON  Month, Days Hours Min.  Sept. 5	27 2005 8:10 Pl  4c. County of Deeth  PRINCE George'S  9. Birthplece (State or Foreit Country)  1924 Virginia  10d. Inside City Limit  17 Yes 2 N  g. Citizen of What Country?  USA  14. Race - American Indian, Black, White, etc.			
4a Fecility Neme (If not institution, give street end number)  FUTURECARE PINEVIEW  5. Sociel Security Number  6. Sex 29-24-0549  1 M 2 F 80  Yrs.  The number of Deeth About Pine Pine Pine Pine Pine Pine Pine Pine	4c. County of Deeth  PRINCE George'S  9. Birthplece (State or Foreit Country)  1924 Virginia  10d. Inside City Limit  Yes 2 N  g. Citizen of What Country?  USA  14. Race - American Indian, Black, White, etc.			
FUTURECARE PINEVIEW  5. Social Security Number  6. Sex 10 M 2 F 80 Yrs.  6. Sex 80 Yrs.  6. Sex 10 Months Days Hours Min.  6. Sex 10 Months Days Hours Min.  7. Age (In yrs. lest birthday) 1 Under 1 Year Hours Min.  8. Date of Birth (Month, Days) 1 Sept. 5  10a. Stete 10b. County 10c. City, Town or Location  10c. Street end Number 10f. Zip Code 10c.	PRINCE George'S  9. Birthplece (State or Foreit Country) 1924 Virginia  10d. Inside City Limit  Yes 2 N  9. Citizen of What Country?  USA  14. Race - American Indian, Black, White, etc.			
5. Sociel Security Number 6. Sex 1 Months Days Hours Min. Sept. 5. Sociel Security Number 6. Sex 1 Months Days Hours Min. Sept. 5. Sept. 5. Sociel Security Number 6. Sex 1 Months Days Hours Min. Sept. 5. Sept.	9. Birthplece (State or Forei Country) 1924 Virginia  10d. Inside City Limit  Very 2 N  g. Citizen of What Country?  USA  14. Race - American Indian, Black, White, etc.			
229-24-0549  Sept. 5  Usuel Residence of Decedent  10a. Stete 10b. County 10c. City, Town or Location  Maryland Prince George's Clinton  10c. Street end Number 10f. Zip Code 10c.	g. Citizen of What Country?  USA  14. Race - American Indian, Black, White, etc.			
Usuel Residence of Decedent  10a. Stete 10b. County 10c. City, Town or Location  Maryland Prince George's Clinton  10e. Street end Number 10f. Zip Code 10e	g. Citizen of What Country?  USA  14. Race - American Indian, Black, White, etc.			
10a. Stete 10b. County 10c. City, Town or Location  Maryland Prince George's Clinton  10e. Street end Number 10f. Zip Code 10e	g. Citizen of What Country?  USA  14. Race - American Indian, Black, White, etc.			
Maryland Prince George's Clinton  10e. Street end Number 10f. Zip Code 10e	g. Citizen of What Country?  USA  14. Race - American Indian, Black, White, etc.			
10e. Street end Number 10f. Zip Code 10e	g. Citizen of What Country?  USA  14. Race - American Indian, Black, White, etc.			
	USA  14. Race - American Indian, Black, White, etc.			
	14. Race - American Indian, Black, White, etc.			
7615 Surratts Road 20735	Black, White, etc.			
11. Meritel Status  12. Wes Decedent Ever in U,S. Armed Forces?  13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.)				
1 Never Married 2 Married 1 Yes 21 No	Specify: WILLICE			
3 ☐ Widowed 4 ☐ Divorced Year or Dates:	Specify: WITITE			
	6b. Kind of Business/Industry			
(Specify only highest grade completed)  (Give kind of work done during most of working life. DO NOT use retired)  Elementery/Secondary (0-12)  College (1-4or 5+)				
Housewife C	own Home			
17. Fether's Neme (First, Middle, Last)  18. Mother's Name (First, Middle, Ma	aiden Surname)			
George Agnor Mary Viola Smith	Acmor			
George Agnor Malling Address (Street and Number or Rurel Route Number, 19e. Informant's Name/Reletionship (Type, Print)  19b. Mailing Address (Street and Number or Rurel Route Number, 19b. Mailing Address)				
Bonnie McKenzie (Daughter) 1190 Siesta Key Circle Port Ora				
1   Rue   2   Compation   3   Removed from State   cemetery, cremetery or other place)	0c. Location - City or Town, State			
Trinity Memorial Gardens 5-5-05	Waldorf, MD			
21. Sign tue of Fe eral Service Licensee 22. Name and Address of Fecility				
1100110	neral Services			
14433 White Pls. La. White F				
23a. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arresponds, or heart failure. List only one cause on each line.	st, Approximate Interval Between Onset and Death			
Immediate Ceuse (Final disease or condition resulting in death)  aAnTERIOSCUSAETIC CALDIOVASCUVA	n nissass year			
resulting in death)  Due to (or es e consequence of):	- year			
b. — Due to (or on a consequence of):	1			
Sequentially list conditions, Due to (or es e consequence of): if eny, leeding to immediate	1			
cause. Enter Underlying Cause (Disease or injury	1			
that initieted events resulting in death) Last  Due to (or as a consequence of):				
<b>U</b>				
Part II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tob	acco use contribute to the cause of deat			
	8 2∭LNo 3 Probably 4 Unkno			

**Physician** /Medical **Examiner** 

within 24 hours aftar death.

To the Funerei Director: After this certificate has been signed by the attanding physician and completaly filled in by the funeral director, page 2 should be detached for use as the burial-transit

or Attending Physician: The law requires that the death cartificate be asscuted

To the Hospital

Division of Vital Records, P.O. Box 68760,

Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Physiclan/Medical Be Completed by

25. Was case referred to medical examiner?

1 ☐ Yes 2 🛣 No

27. Menner of Deeth

1 Natural

2 Accident

3 Suicide

4 Homicide

Physician

**Examiner** 

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23s or 28s-f show any injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0020

/Medical

Director

Funeral

Be Completed by

2

5 Pending investigation

6 Could not be determined

Part II. Other eignificent condit

24a. Was an eutopsy parformed?

24b. Were autopsy findings available prior to completion of cause of death?

1 1 Yes

1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

Other:	4 Nursing I	lome	5 □ Res	sidence	6 □Other	(Specify)
	-					

28c. Injury et Work? 28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No 28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of Injury

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

29a. Certifier (Check only one) Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner stated. 29c. License number 29b. Signature end title of certifier

28a. Dete of Injury (Month, Dey Year)

М

Registrar

Medicai Certification: To

0 2 2005 Signeture

Certificate of Death

Division of Vital Records, P.O. Box 68760,		Baltimore, Maryland 21215-0036
To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death	Phy /M Exa	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hydiene.
To the Funerel Director: After this certificate has been signed by the attending physician and		Important: If Item 27 is marked other than "natural", or Itams 23a or 28a-f show
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	ia ic:	eny injury or other traumatic event, the Medical Examinar must be notified at

1 - For State Registrar

Physicia /Medica Examina

Funeral Director

	Geor			onovi	ch	Rak	ochev	rsky				Month Apri	0	4,20	Year 05	4:05a M
	4a. Facility Name (/		-			ital	4b.	City, Tow		ocation (	of Death		4		of Death	nery
	5. Social Security N 124-28-	lumber	6. Sex	M 2□F	7. Age (In y	rs. last birtl		Inder 1 You	Bar	If Under Hours	24 Hrs. Min.	8. Date of B (Month, D	ay, Yea			place (State or Foreign ntry)
5	Usual Residence of 10a. State Md	10b. Count Mont	•	ery		City, Town Brool						4/02	1 1 3			l0d. Inside City Limits
2010	10e. Street and Nut		line	Plac	ce		10	of. Zip Coo	083	33			10g. (	Citizen of USA	What Cour	ntry?
y i dilei	11. Marital Status 1 ☐ Never Marr 3 🛣 Widowed		rried	2. Was Dec Armed Fo 1 Tes If Yes, Gi Year or D	2 ₩ No	n U.S.		Decedent , specify ( es 2 🕱		anic Ori Mexicar Specify:		ecify Yes or N Rican, etc.)	0-		ck, White,	can Indian, etc. nite
To be completed by Fulleral Director		15. Decede	nt's Educ	ation completed) Coltege (		16a.	Decedent's (Give kind life. DO N	of work de OT use re	one du stired)	on ring mos	t of work	king	16b.		usiness/In	
ס מס	17. Father's Name Anton I			5+ h			Geo.	1091				e (First, Middl Rabc		en Sumar		
	19a. Informant's Na Natasha				ghter		Mailing Ad	dress (St	reet an	d Numbe	rorAu St	ral Route Num. Creet	ber, City Oln	ey,	State, Zip 1d 20	0 8 3 2
	20a. Method of Dis 1 XrBurial 2 4 □ Donation			moval from		b. Place of cemetery Rock	Disposition y, cremator Cre	y or other	f place)	4		Date / 2005			· City or To	
	21. Signatur	negal Service	well	2.			PHT:	LIP <sup>A</sup> 1 Co	b. 1u	R'ÍN' mbia	XLDI a Bl	FUNE Lvd.Si	RAL lve	SEE r S	RVICI oriņ	E,P.A. g,Md2091
	23a. Part1. Enter t shock, or hea Immediate Cause disease or condition resulting in death)	irt failure. Lis (Final	or complications only one	cause on Ce	caused the deach line.  rebra (or as a cons	l He	mmor			such as	cardiac	or respiratory	arrest,		!	Approximate Interval Between Onset and Death  days
מוניווובמוכמו בצמווווונו	flamy, leading to in cause. Enter Unde Cause (Disease or that initiated events resulting in death)	injury s	b. c.	Ce Due to	rebra (or as a cons	al Va	scul	ar I	Dis	eas	e					
	IF FEMALE: 23b. Was deceden in the past 12 1  Yes 2  9  Unknown	months? ⊒No	23	1 Live	itcome of pre birth 2 F nant at time o	etal death		pic pregn er <i>(specif</i>							ite of delive	ery Day Year
	Part II. Other signi		tions conf	ributing to o	leath but not	resulting in	the underly	ying caus	e giver	in Part I				o use con 2 ⊈No		he cause of death?
5000								<del></del>					opsy formed?	,	Were auto prior to co death? 1 \( \sum \text{Yes}	psy findings available impletion of cause of
	25. Was case reference examiner?			ospital:					Other	777	-	th (Check only				
medical celunication: 10	1 ☐ Yes 2 ☑  27. Manner of Deat  1 ☑ Natural  2 ☐ Accident	th 5 🗆 Pend		28a. Date		2 ER/Out 28b. T r) Ir			Injury a	4 🗀 140		28d. Describe				(y)
	3  Suicide 4  Homicide	6 🗌 Could deter	d not be mined	28e. Płac build	e of Injury - A ling, etc. (Sp	At home, far ecify)	rm, street, f	actory, of	fice			28f. Location City or To			ber or Rura	al Route Number,
מוכמו	29a. Certifier (Check only one)	1 ☐ Certify 2 ☐ Medica	ing Phys Il Examin	ician: To the er: On the tand man	e best of my pasis of exam nner stated.	knowledge, nination and	, death occ d/or investig	urred at th	ne time my opii	, date an nion, dea	nd place, ith occur	and due to the red at the time	e cause , date a	(s) and m ind place,	anner as s and due to	tated. the cause(s)
1	29b. Signatule and	tive of certif	ier	3,		Q	dy		5 8 (	09					d (Month,	Day, Year)
	30. Name an ad John G	1.0			se of death (	item 23a) ( Oln	Type, Print	) andy	, S	pri	ng I	Rd Oln	ey,	Md	2083	32

State

Registrar

31. Date filed (Month, Day, Year)

APR 2 9 2005

December Name (Post Anthon)			1- For Amend Item 23		ME, G84	3.02/	tificate of	Death		Reg. No	2005	16331
## Course of Death   Frederick   Frederick				t)	Ro	bins	on		Month	Da	<sup>Y</sup> 2005	3. Time of Death 5:15am M
S. Social Security Juneaus  Juneaus  S. Social Security Juneaus  Juneaus  S. Social Security Juneaus  Jun			_	•	)2				ath	40	,	
Control of State and American   Tool Capt   Town of Location   Town			-						n. (Month, D	rth ay, Year)	9. Birt	hplace (State or Foreig
Secretary   Board of Education   Secretary	show	or.	10a. State 10b. County	ick						,		10d. Inside City Limit
Bear of Education   Secretary   Board of Education   Board of Ed	a or 28a-1 Le notifi	Direct	10e. Street and Number		<u> </u>	Tede	10f. Zip Code	04700		10g. Cit	tizen of What Co	
20a. Method of Disposition 1   Bural 2 % Cremation 3   Removal from State 4   Dogation 5   Other (Speech) 21. Signature of Fueral State (London) 22. Name and Address of Facility 23. Name and Address of Facility 24. Signature of Fueral State (London) 25. Signature of Fueral State (London) 26. Place of Disposition (Name of Disposition) 27. Name and Address of Facility 28. Receive & Bassford P. A. Funeral Home 28. Part I. Early foot Licensee  NO706	, or Items 23 aminer must		11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent I Armed Forces? 1 Yes 2 N	Ever in U.S.		/as Decedent of F Yes, specify Cuba	lispanic Origin? an, Mexican, Pue	(Specify Yes or No erto Rican, etc.)	0-	14. Race - Ame Black, White	e, etc.
20a. Method of Disposition 1   Bural 2   Cremation 3   Removal from State 2   Comments	ne. han "natural a Medical Ex		15. Decedent's Ed (Specify only highest grad	ucation de completed)		(Give k	aind of work done O NOT use retired	ation during most of w	orking		ind of Business/l	ndustry
20a. Method of Disposition 1   Burial 2 (2) Cremation   Signature   Date   Concentration   Signature   Date   Concentration	ad othar t	Be	_	33	То				ame (First, Middle		Sumame)	
20a. Method of Disposition 1   Bural 2 X Cremation   3   Removal from State 20a. Method of Disposition 1   Bural 2 X Cremation   3   Removal from State 2   A   Congains   5   Congression   3   Removal from State 2   Single 5   Single 6   Respect   2   Congression   3   Removal from State 2   Single 6   Respect   2   Removal Single 6   Respect   2   Respect   2   Removal Single 6   Removal S	7 Is mark raumatio	To	19a. Informant's Name/Relationship (T	ype, Print)	1	9b. Mailing	Address (Street	and Number or F		-	r Town, State, Z	ip Code)
Aparti. End endicate or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arest.    Aparticipate of death of the disease, or completations that cause on each line.	or Hear fitam 2 or othar		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ I	Removal from State	20b. Place ceme	of Dispos tery, crem	ition (Name of atory or other plac	ce)	Date	20c. Lo	ocation - City or T	own, State
Approximate and the design of contribute to the cause of death?    Perforated Abdominal Bowel   Sequentially list conditions are consequence off;   Due to (or as a consequence off);   Due to (or as a consequenc	Uepartme Important any injury once.		21. Signature of Funeral San ice Licens			22.	Name and Address	ss of Facility				100
Due to (or as a consequence of):  Probable Diverticulitis  Sequentially list conditions, cause. Entire Underlying cause. Entire Underlying cause is the function of the cause of the composition of the cause of the composition of the cause o	ysician	) ( )	23a. Part 1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition	lications that caused ne cause on each lin	the death. D	o not ente	r the mode of dyin	g, such as cardi	ac or respiratory a	rrest,	, Maryla	Approximate Interval Between
FFEMALE:	100		that initiated events	Due to (or as a	i consequenc	e ofj.	iculitis		ON APPROVED BY	MEDICAL	EXAMINER	
Gastroesophageal Reflux Disease    1   Yes   2   No   3   Probably   4   Unknown	attending for use as	ysician/Med	23b. Was decedent pregnant in the past 12 months?  1 \( \subseteq \text{Yes} \) 2 \( \subseteq \text{No} \)	1 ☐ Live birth : 4 ☐ Pregnant at	2 ☐ Fetal dea			CEKIIJO			23d. Date of deliv	
28a. Was case referred to medical axaminer; 1 Yes 2 No  25. Was case referred to medical axaminer; 1 Natural 2 North Nor	an signed b	by				in the unc	derlying cause give	en in Part I.				
1   Yes   2   No.   1   Inpatient   2   ER/Outpatient   3   DOA   2   4   Nursing Home   5   Residence   6   Other (Specify)	ate has page 2	O.							autop perfo	sy rmed?	prior to co	mpletion of cause of
D31912 April 15, 2005	.e :5	ToB	examiner? 1 X Yes 2 No.  27. Manner of Death 1 X Natural 5 □ Pending	28a. Date of Injury	/ 28b	Time of	28c. Injury Work	at ?	Home 5 Resid	dence 6		(y)
D31912 April 15, 2005	aral Directo		4 Homicide determined	building, etc.	(Specify)				City or Tox	vn, State)	)	
D31912 April 15, 2005	tha Fune		one) 2 Medicel Exami	ner: On the basis of	examination a	ge, death o nd/or inve	stigation, in my or	inion, death occ	urred at the time,	date and	place, and due to	the cause(s)
	To cor		290. Signature and title of certifier	1 n								

Joan Rohme 05-2985 AKG

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death . 2005 **Physician** April 30, Rudd Rohme Joan 3:07 A /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George's Hospital Center Cheverly Prince George's If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Nov 30, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 M 2 F 57 226-64-8159 Director Virginia Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at Prince George 1 XYes 2 □ No Directo Maryland Riverdale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 "netural", or items 23e 5303 Hamilton Street 20781 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If item 27 Is marked other than "netural", or Ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Albert Austin Rudd Mary Elizabeth Wooldridge 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frank E. Rohme - Husband 5303 Hamilton Street, Riverdale, Maryland 20781 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State permit. Pages 1 Depertment of H Important: If ite any injury or ot once. Chesterfield Baptist May 4, 2005 Moseley, Virginia 1 XBurial 2 □ Cremation 3 Removal from State \* 4 □ Donation S □ Other (Specify Church Cemetery 21. Signature of meral Service Li 22. Name and Address of Facility 14301 Ashbrook Parkway Bennett Funeral Home Chesterfield, VA 23832 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Upper gastrointestinal Priysician /Medical Examiner amodena1 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) The law requires that the death certificate be executed nding physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? Month Day 4 Pregnant at time of death 5 Cther (specify) P.O. 9 Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records. 1 Yes 2 No Be Completed 3 ☐ Probably 4 ☐Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ▼Yes 2□ No 24a. Was an page 2 1 Yes 2 No Hospitel or Attending Physicien: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) examiner: XXYes 2□ No Hospital: Other: Certification: To 1 ☐ Inpatient 🗶 ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending after death. Director: A 2 Accident investigation 1 ☐ Yes 2 ☐ No the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

XX Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) To the To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. April 30, 2005 of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 1111 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

		State of Maryland / Der TH, G8	partment of Health and Merilia Care of Beath	lental Hygien	005   6336
	nysician Medical	1. Decedent's Name (First, Middle, Last)  Margaret Katherine Shrout		2. Date of Death  April 26	3. Time of Death
	xaminer	4a. Facility Name (If not institution, give street and number) Lions Manor Nursing Home	4b. City, Town, or Location of Death Cumberland		County of Death
	neral ector	5. Social Security Number 236–42–0099 6. Sex 1 M 2 F 7. Age (In yrs. last birthda) 78 Yrs.	// If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year, Aug. 20, I	9. Birthplace (State or Foreign
ne Maryland	Affied at	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or I  WV Hampshire Romney			10d. Inside City Limits Y⊟ Yes 2 □ No
with the	Dire	380 N. Grafton St.	10f. Zip Code 26757	10g. Ci	itizen of What Country?
Shrout, Margaret K.  Baltimore, Maryland 21215-0036  permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hydione.	by Funeral Director		Was Decedent of Hispanic Origin? (Sprif Yes, specify Cuban, Mexican, Puerto		14. Race - American Indian, Black, White, etc. Specify: White
Shrout, Margaret altimore, Maryland 21215-0036 mil. Pages 1 and 2 should be filed within 72 hours at partnered to Honelly and Market by pagental it it item? I see marked other than "natural" or partnered.	t, the Medical E	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of worki DO NOT use retired)	ing 16b. K	Kind of Business/Industry
22.	Com	8	Homemaker		Home
and	c evan	17. Father's Name (First, Middle, Last)		(First, Middle, Maider	n Sumame)
Maryland 212: Maryland 212:  A should be filed within and Maryland a Maryland by the should be filed within the and Maryland by the should be shou	traumatic		ling Address (Street and Number or Rura alley Street, Romne		
imore,	y or other	20a. Method of Disposition  20b. Place of Disposition  20b. Place of Disposition  20b. Place of Disposition  20b. Place of Disposition		705 20c. L	ocation - City or Town, State Cee Churches, WV
Baltir Permit. P	any injur once.	21. Signature of Funeral Service Licensee	Shaffer Warnick Fur 230 E. Main St., Ro	neral Home	
Physical Physician and physici	dical	23a. Pad. Enter the disease, or complications that caused the death. Do not explose, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to infine diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):	Candiovascula		Approximate Interval Between Onset and Death  C. G. M. C. M. C.
15, 16  Records, P.O. Box 687  The law requires that the death certificate to has been stoned by the attending physical parts at the page of the street of t	letached tor use as Physician/Mec		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery  Month Day Year
ds, P.	d by Ph	Part II. Dther significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco t	use contribute to the cause of death?
I Re la The la te has	0 0			24a. Was an autopsy performed? 1 ☐ Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 No
Vit	I director	25. Was case referred to medical examiner?  1  Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatie	26. Place of Death ont 3 DOA Other: 4 Nursing Hor	(Check only one)	6 DOthor (Capaida)
ion of ading Phys. th.	funeral ontion: T	27. Namer of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation		28d. Describe how injur	
Divisio al or Attendi s after death.	ed in by the funera	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Street an City or Town, State	nd Number or Rural Route Number, a)
Division of Vita To the Hospital or Attending Physician: within 24 hours after death.	completely tilled in by the funeral director, page  Medical Certification: To Be Com	29a. Certifier (Check only one)  12 Certifying Physician: To the best of my knowledge, deal control on the basis of examination and/or in and manner stated.	th occurred at the time, date and place, a nvestigation, in my opinion, death occurre	and due to the cause(s) and at the time, date and	) and manner as stated. d place, and due to the cause(s)
To the within	woo lwoo	29b. Signature and title of certifier  workerfulfin MC	29c. License number # D55335		te signed (Month, Day, Year)
2		30. Name and address of person who completed cause of death (Item 23a) (Type Wonsock Shin MD 48 Tarn	# D55325 Terrace Frostbi	. 150 115	21622
B	State egistrar	31. Date filed (Month, Day, Year) 32. Registrar's Control MAY 1 3 2005	MINISTER THE STORY	My, MD	0122d

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day John Henry Stoner, Jr. apri 27 2005 /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Washington County Hospital Hagerstown Washington 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Months 1 XM 2 ☐ F Director 204-01-5352 86 05/22/1918 PA Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits Examiner: set be nutified at Director Washington Hagerstown Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 856 W. Irvin Avenue 21742 US Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Iter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Completed by Specify: Black 3 ☐ Widowed 4 ☐ Divorced permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturany injury or other treumatic event, If a Medical once. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Laborer Railroad 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James Henry Stoner Jesse Matilda Cuff ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10213 Summers Lane, Hagerstown, MD 21740 Thomas H. Stoner / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State ` 4 ☐ Donation 5 ☐ Other (Specify) Cedar Lawn Mem. Park 05/03/2005 Hagerstown, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gerald N. Minnich Funeral Home 305 N. Potomac Street, Hagerstown, MD 21740 Approximate Interval Between Onset and Death 1 - 2 ///// 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Probaste Priysician Myvindel disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner endio myo EMS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events by Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certilicate be executed use as the burial-transit ENKS resulting in death) Last Due to (or as a consequence of): physician IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown ģ Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 PKNO 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 🗷 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Atter 28d. Describe how injury occurred 1 Natural 5 Pending death. nours after death.

neral Director: A
tilled in by the to investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗍 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 0 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

Division of Vital Records, P.O. Box 68760.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHTTAIN RMIL 190 MT ATTHE ROM)

ZUUD

32. Registrar's Signature

31. Date filed (Month, Day, Year)

APR 28

			1 - For State Registrar		Maryland / Dep		f Health a	nd Mental H	-	ible.
	Physic /Medi Exami	ċal.	Decedent's Name (First, Middle, I Annice Leora ST     4a. Facility Name (If not institution, g	ELZER	•	4b. City, Town	n, or Location of	2. Date of I Month	Day	Year 3. Time of peath 705 6 1 P M
	Funeral Director		Washington Cour 5. Social Security Number 6 213–12–7007		a1 Age (In yrs. last birthday 84 Yrs.			4 Hrs. 8. Date of 8	Birth Day Year)	9. Birthplace (State or Foreign
	<b>0</b>		Usual Residence of Decedent  10a. State 10b. County  Maryland Wasi	nington	10c. City, Town or L	ocation serstown		July	14, 1920	Maryland  10d. Inside City Limits 1☑Yes 2□No
	be lied within 72 hours atter death with the Maryland thygiene. d other than "natural", or items 23e or 28e-f show event, the Madical Examinational be maillied at	Funeral Directo	10e. Street and Number 250 Nottingham I	12. Was Deceder	nt Ever in U.S. 13.		21740	in? (Specify Yes or I Puerto Rican, etc.)	10g. Citizen of V USA No- 14. Rac	What Country?  e - American Indian,
5-0036	2 hours after atural', or ite cal Examina	by	1 Never Married 2 Married  3X Widowed 4 Divorced  15. Decedent's	Armed Force: 1  Yes 2½ If Yes, Give Year or Dates	S: 16a. Dece	1 ☐ Yes 2 🛣 N	No Specify:		Specify	white, etc.  white usiness/Industry
d 21215	riled within 7. Hygiene. other than "n. ent, it e M.d.	Completed	(Specify only highest g  Elementary/Secondary (0-12)  1 2  17. Father's Name (First, Middle, La	College (1-40	(Give life.	skind of work do DO NOT use ret sonnel	ne during most d ired) clerk		U. S.	Government
ırylan	should be nd Mental marked c	To Be	Russell F. Pow	re11 (Type, Print)	19b. Mail	ng Address (Stre	C1a	s Name (First, Midd Ara A. Mow or Rural Route Num	en	
o ·	permit. Fages 1 and 2 Department of Health a Importent: If item 27 Is any injury or other trau		Beverly Fisher -  20a. Method of Disposition  1 Burial 2 Scremation 3  4 Donation 5 Other (Spec	□Removal from Stat	20b. Place of Dispresentery, cre Hagersto	osition (Name of matory or other p wn Crema Name and Add	atory 4		20c. Location - Hagers FUNERAL	City or Town, State town, Maryland HOME
	nysician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions. If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or a	ed the death. Do not en		lying, such as ca	.vd., Hage ardiac or respiratory	arrest,	Md. 21740  Approximate Interval Between Onset and Death  2 6 7
ם ו	e attending p	hysician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 25 No 9  Unknown		2 Fetal death 3	□Ectopic pregnar □ Other (specify)			23d. Date Mor	e of delivery hith Day Year
ecords, P.O	been signed by the should be detached	leted by Ph	Part II. Other significant conditions	contributing to death	but not resulting in the u	nderlying cause (	given in Part I.		_	ibute to the cause of death? 3 ⊠Probably 4 □Unknown
ב ב	ate has	e Comple	25. Was case referred to medical					1 ☐ Yes	opsy p ormed? d 2/Z/No 1	Vere autopsy findings available nor to completion of cause of eath?  Yes 2 No
DIVISION OF VICE	Ta la	Certification; To Be	27. Manner of Death  1 Shatural 5 Pending investigating a Suicide 4 Homicide	28e. Place of Ir	iury 28b. Time o	M 1	other: 4 □ Nursi jury at fork? □ Yes 2 □ No	28f. Location	idence 6 □Othe how injury occurre	or (Specify) ad or or Rural Route Number,
the Moonit	hin 24 hours the Funerel	Medical C	one)	hysician: To the bes miner: On the basis and manner s	it of my knowledge, death of examination and/or in stated.	vestigation, in my	opinion, death	place, and due to the occurred at the time	, date and place, a	nd due to the cause(s)
г Би	TY Sor Tailit	V	29b. Signature and title of certifier  30. Name and address of person who	completed cause of	20 0 60	DS2	-3 2 3		4/251	(Month, Day, Year)
OHMI	Sta Registr	ar	31. Date filed (Month, Pay, Year)	2005 32. Harrist	trar's Signature	ourl ack	100	Med 21	742	

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death **Physician** auts SWITH JR 9:05AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Randallstown B<u>altimore</u> Northwest Hospital Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1⊠M 2□F Director Yrs. 214 40 6267 63 1941 Oct 21, Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Madical Examiner must be notified at 1 Yes 2 No Director MD Baltimore Woodlawn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1429 Barrett Road or items 23a 21207 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1X Yes 2 No If Yes, Give Year or Dates: 1960-64 hours efter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: "natural", 3 ₩idowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Security Guard Giant Food permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy.
Important: If Item Z7 le markad other any injury or other traumatic mand 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) James Edward Smith Sr. Clara Lowe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1227 Stamford Road Baltimore, MD 21207 Clara Linthicum/Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory 5-3-2005 Catonsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityHarry H. Witzke's Family FH Inc. M01044 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): **Examiner** ESRO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-transit DW Due to (or as a consequence of): Box 68760 attending physicien Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 2 No 1 Tes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an certificate has autopsy Division of Vital 1 Yes 2 PNo 1 Yes the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: patient 1 Yes 2 Vo 2 ☐ ER/Outpatient 3 DOA this After this funeral of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification; Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) hours after 4 Homicide within 24 hours a To tha Funeral C 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of persor completed cause of death (Item 23a) (Type, Print)
T. IMPERIAL, TR. NWHC 31. Date filed (Month, Day, Year) 32. Regitrar's Signature State Registrar

		1 - For State Registrar	State of Maryland / I	Department of Health and Certificate of Death		0000	1701
				Certificate of Death	Reg.	No:	
Physic		1. Decedent's Name (First, Middle, Last) Sharay	L	Smith	Month	Day Year	3. Time of Death
/Medi Exami		4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of Dea		4c. County of Deat	
EXAIIII	itei	Johns Hookins		Baltimore	city		
Funeral		Social Security Number     6. Security Number		nthday) If Under 1 Year If Under 24 Hr. Months Days Hours Min		9. Birt	hplace (State or Forei
Director		214-76-6412	™ <del>2</del> 5	Yrs. Month's Days Hours Min	5-29-19	69 Mai	ryland
3 *		10a. State 10b. County	10c. City, Tow	n or Location			10d. Inside City Lim
rations are real muture margana "naturat, or tems 23a or 28a-f show offer Examination of the definition	tor	Maryland Anne Ar	undel Anna	apolis			1 X Yes 2 □
or 28	Director	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Co	untry?
238	rai	1208 Hollyday Ct.		21403		USA	
tem	Funeral	The state of the s	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Ame Black, Whit	
r', or	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	1 ☐ Yes 2 █ <b>X</b> No If Yes, Give Year or Dates:	1 ☐ Yes 2 💢 No Specify:		Specify: W	nite
atora	ed	15. Decedent's Edu	cation 16a	Decedent's Usual Occupation	166	o. Kind of Business	Industry
. 2	Completed	(Specify only highest grade Elementary/Secondary (0-12)	e completed)  College (1-4or 5+)	(Give kind of work done during most of we life. DO NOT use retired)	orking		,
	mo.	12th	College (1-401 34)	Cosmetologist		Beauty Sa	alon
d other	BeC	17. Father's Name (First, Middle, Last)		18. Mother's Na	me (First, Middle, Mai	den Sumame)	
	70	Paul A. Smith	n	Car	olyn M. Wi	lley	
th and Mer 7 is marke traumatic	ľ	19a. Informant's Name/Relationship (Ty	rpe, Print) 19b	o. Mailing Address (Street and Number or F	lural Route Number, Ci	ity or Town, State, 2	Zip Code)
m 27 her tr		Carolyn M. Smith/		208 Hollyday Ct., Ar			
		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F	Removal from State 20b. Place o	f Disposition (Name of ry, crematory or other place)	Date 200	. Location - City or	Town, State
ment: ant: ury	1	4 Donation 5 □ Other (Specify)			29-05 D	avidsonvi	lle, MD
Department of Important: If its any injury or of once.		21. Signatur & Funeral Service Ricens	89	22. Name and Address of Facility	George P. K	alas Fune	eral Home
6620		Jamil Uc	uc-	2973 Solomons Isl			MD 21037
nysician		23a. Part1. Enter the disease, or compleshock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ications that caused the death. Do ne cause on each line.	not enter the mode of dying, such as cardia	ic or respiratory arrest.		Approximate Interval Between Onset and Death 2
/Medical xaminer			Due to (or as a consequence	onsis exacerbot	45		3 week
	io io	Sequentially list conditions.	Due to or as a consequence		719		364656
insit	m in	Sequentially list conditions, and the sequentially list conditions, cause. Enter Underlying Cause (Disease or injury					
ysician and e burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a consequence	of):			
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attending phy I for use as the	Physician/Med	23b. Was decedent pregnant	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death	n 3 □Ectopic pregnancy		23d. Date of del	
he att	sick	in the past 12 months? 1 \sum Yes 2 \text{VNo}	4 Pregnant at time of death 9 Unknown	5 Other (specify)		Month	Day Year
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ite has been signed by the attending ph	ted				1 Tes	2 No 3 □ Pr	obably 4 Donkild
has b ge 2 st	Completed				24a. Was an autopsy	prior to	topsy findings availa
ate ha	Con				performed 1 Yes 2		2 🗆 No
	Be	25. Was case referred to medical examiner?	I Wall		eath (Check only one)		
		1 Yes 2 No	lospital: 1 inpatient 2 ☐ ER/O		Home 5 Residence		cify)
is certifica director, p	မ	27. Manner of Death		Time of 28c. Injury at Work?  M 1 □ Yes 2 □ No	28d. Describe how i	njury occurred	
is certifica director, p	H-	1 Natural 5 ☐ Pending		M 1 ☐ Yes 2 ☐ No		A most Africantina and Di	ral Pouta Number
is certifica director, p	H-	1 Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	29a Place of Injury . At home for	are street fester; office	28f Location /Stree		
is certifica director, p	H-	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	28e. Place of Injury - At home, fa building, etc. (Specify)	arm, street, factory, office	28f. Location (Stree City or Town, S		,
is certifica director, p	Certification; T	1 Natural 5 Pending investigation 3 Suicide 4 Homicide 6 Could not be determined	building, etc. (Specify) sicien: To the best of my knowledg ner: On the basis of examination ar	e, death occurred at the time, date and placed/or investigation, in my opinion, death occ	City or Town, S	fate) e(s) and manner as	stated.
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is certifica	edical Certification; T	1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)  29b. Signature and title of certifier  Madural 5 Pending investigation 6 Could not be determined	building, etc. (Specify) sicien: To the best of my knowledg ner: On the basis of examination ar and manner stated.	e, death occurred at the time, date and placed or investigation, in my opinion, death occurred 29c. License number	e, and due to the causurred at the time, date	e(s) and manner as and place, and due Date signed (Monti	stated. to the cause(s)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. -1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day 640 PM EHANH 8-2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1. +4 Kockvil Montgomere FROVE (E If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 25 E 218-57-1239 Yrs Director 41 AKISTAN Usual Residence of Decedent death with the Maryland 10a. State 10h County 10c. City, Town or Location orrant: It itam 27 is marked other then "natural", or Itams 23a or 28a-1 show injury orother traumatic event, the Medical Examirae must be notified at 10d. Inside City Limits MALYLMO 1 Xes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? FARBOR 208 PAKISTAN 12104 Completed by Funeral 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or Itar may injury prother traumetic event. Its Wedical Examinations. Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Asian 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ANWAR ame/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, 21041 HUSBAND 20b. Place of Disposition (Name of crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) AlcistAN 22. Name and Address of Facility of Whileson 21. Signature of Funeral Service Licensee ST., N. W. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final hoc **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** tro penia Sequentially list conditions, Examiner r any leading to immedicause. Enter Underlying Cause (Disease or injury the attending physician and thed for use as the burial-transit e m that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death, but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ tastatic breast 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 1 Yes 2 No 2□ No To the Hospital or Attending Physician: director 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 26 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes npatient this 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Mann Death 28b. Time of 28c. Injury at Work? After t Certification: 28d. Describe how injury occurred 1 Natural 5 Pending death, 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funaral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 10 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and, 29c. License number 29d. Date signed (Month, Dey, Year) D0054068 28 2 30. Name and a dress of person who completed cause of death (It) 23a) (Type, Print) Shady Grove Kockyille ary 31. Date filed (Month, Day, Year) Registrar's Sign ture State APR 29 Registrar

			. For	State of Maryla				•	•	10010
			1 - State Registrar		•	rtificate of		Reg. N	2000	16342
П	Physici	an	1. Decedent's Name (First, Middle, Last)		1:1	1		2. Date of Death Month D	ay, Year	3. Time of Death
	/Media	cal	4a. Facility Name (If not institution, our	street and number)	/V / T	4h City Town	or Location of Death	.5	c. County of Death	1604
1	Examir	ıer	a 1 1 1	spice at 1	ako	4b. Oily, Town,	lisbut			nico
	Funeral		Social Security Number 6. Sex	7. Age (In yr	s. last birthday)	If Under 1 Year Months Days	If Linder 24 Hrs	O Date of Dist	0.00	lace (State or Foreign
	Director		218-05-8886 N	M 20 F 89	Yrs.		J	anuary 28,	1916  Maryl	länd
	yland		10a. State 10b. County	10c. C	City, Town or Lo	ocation			1	Od. Inside City Limits
	e Mar	ctor	Maryland Wicomi	ico		Del	lmar			1 ☐ Yes 2 ☐ No
	with th	Director	10e. Street and Number			10f. Zip Code		10g. C	itizen of What Coun	itry?
	leath v	Funerai	31871 Downing Road	12. Was Decedent Ever in	U.S. 13.	Was Decedent of I	21875	city Yes or No-	14. Race - Americ	
9	after d	Fun	1 ☐ Never Married 2 ☒ Married	Armed Forces? 1 ☐ Yes 2 X No			Hispanic Origin? (Spec an, Mexican, Puerto F	lican, etc.)	Black, White,	etc.
21215-0036	72 hours after death with the Maryland Insturel', or Items 23a or 28a-f show Jissel Enactinet must be multical at	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1□Yes 2XNo				nite
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212	i the	mo	Elementary/Secondary (0-12) 4	College (1-4or 5+)		Farme			Farmi	na
	be filed vital Hygie of other terms	Bec	17. Father's Name (First, Middle, Last)				1	(First, Middle, Maide		
Maryland		Lo	Norman Cleveland S					ia Swift		
Mai	S Es as		19a. Informant's Name/Relationship (Ty) Betty L. Sterling				<i>and Number or Rural</i> Street - Cr		100	•
re,	of Health of Health filem 27		20a. Method of Disposition	20b.	Place of Dispo	sition (Name of matory or other pla	Da		Location - City or To	
imo	Pag nent ant: I		1 X Burial 2 ☐ Cremation 3 ☐ R  `4 ☐ Donation 5 ☐ Other (Specify)			Memorial Pa	1	2005 Cris	sfield, Ma	ryland
Baltimore,	permit. Pag Department Important: I any injury o		21. Signature & Funeral Service License	Brakkou	27/ 27	2. Name and Addre	& Sons Fur			
	PO F e O		Mary Beth Brads			306 W. Ma	in Street	- Crisfie		and 21817 Approximate
Į,	Physician :		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final	ne cause on each line.	`c		_	respiratory arrest,		Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a conse	equence of):	CANC	12/2			1 year
	Examiner	_	Sequentially list conditions,							
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause (Disease or injury	Due to (or as a conse	equence of):					
oʻ	be executed sician and burial-transit	Exa	that initiated events resulting in death) Last	Due to (or as a conse	equence of):					
8760	e X	licai		d						
x 68	death certificat e attending phy d for use as th	/Med	IF FEMALE:	3c. If yes, outcome of preg	nancy					
Вох	at at	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 □ Live birth 2 □ Fe 4 □ Pregnant at time of	tal death 3	Ectopic pregnancy Other (specify)	у		23d. Date of delive Month	ny Day Year
P.0	that the de ned by the a detached t	hys	9 🗆 Unknown	9□ Unknown						
	e igi	by	Part II. Other significant conditions con	ntributing to death but not re	sulting in the u	nderlying cause giv	en in Part I.		use contribute to th	e cause of death? ably 4 □Unknown
Records,	w requir	letec	P					24a. Was an	/	
Re	The lay ate has page 2:	ompleted						autopsy performed?	prior to con death?	osy findings available inpletion of cause of
Vital		BeC	25. Was case referred to medical examiner?				26. Place of Death	1 ☐ Yes 2 N (Check only one)	o 1 Yes	2 🔀 No
of V	S =	2	1 ☐ Yes 2 No	lospital: 1 Inpatient 2[		IL DON		e 5 🗆 Residence	7	HOSPICE
	ding h. After fune	tlon	27. Manner of Death  Natural 5 Pending  Natural investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wor	ryat 28 rk? Yes 2 ☐ No	3d. Describe how inj	ury occurred	
Division	Attending or death.	ertification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, larm, str			31. Location (Street a	and Number or Rural	Route Number,
	ital or its afte ral Dir led in	0	4 - Horniolde	building, etc. (Spec	ary)			City or Town, Sta	(9)	
	To the Hospital or Attendi within 24 hours after death To the Funeral Director: / completely filled in by the fo	edical	29a. Certifier (Check only one)	sician: To the best of my kr ner: On the basis of examin and manner stated.	nowledge, death nation and/or in	n occurred at the tir vestigation, in my o	me, date and place, ar opinion, death occurred	nd due to the cause( d at the time, date ar	s) and manner as stand place, and due to	ated. the cause(s)
	To the within 2. To the complet	Me	29b. Signature and title of certifier	and massion stated.		29c. Licens	se number	29d. D	ate signed (Month, E	Day, Year) .
			& Slulan	i An	2	000	58410		5/7/05	
	3		30. Name and address of person who co	empleted cause of death (Ite	om 23a) (Type,		SALIS	0 - 1 21 :		
	Sta	te	31. Date liled (Month, Per Year)	32. Palistrar's Sign	laturo		5 A L(S	runga	45 010	
	Registr	ar	31. Date liled (Month, MAY 1 3 2	005 Serene	15 A	beed!				

				State of Manuard / Depart		•	•	1 2 22 1 44
				1- State of Maryland / Depart FH/Dr. Corn	43,05/13/05dfb Miricate of Death	Reg	No.	16343
		Dhuoini	-	Decedent's Name (First, Middle, Last)		2. Date of Death	Pay Year	3. Time of Death
		Physici /Medi		Maryrita I I homas		April 3	2005	22:55 Рм
		Examir	ier		4b. City, Town, or Location of Death		4c. County of Death	1
				Hasford Memorial Hospital  5. Social Security Number 6. Sex 7. Age (in vs. last birthday)	Havre-de-Gra If Under 1 Year   If Under 24 Hrs.	8 Date of Birth	Harto	Nana (State or Foreign
-		Funeral Director			Months Days Hours Min.	8. Date of Birth 12/3/50	ear) Cour Mary	place (State or Foreign htry) and
		pu >		Usual Residence of Decedent         10a. State         10b. County         10c. City, Town or Local	41			
		sho	5	0,0			1	0d. Inside City Limits 1 ☐ Yes 2 🛪 No
		the A	Director	100. Street and Number	epos it	100	Citizen of What Cour	
		be filed within 72 hours after death with the Maryland Ital Hygiene. d other than "natural", or Itams 23a or 28a-f show event, the Medical Exam, are must be rectified at		5 Birch Court	21904		U.S.A.	,
		deatl	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Wa Armed Forces? 13. Was Decedent Ever in U.S. 14. Was Decedent Ever in U.S. 15. Was Decedent Ever in U.S. 16. Was Decedent Ever in U.S. 17. Was Decedent Ever in U.S. 18. Was Decedent Ever in U	as Decedent of Hispanic Origin? (Spe es, specify Cuban, Mexican, Puerto I	cify Yes or No-	14. Race - Americ Black, White,	
	36	or It	by Fu	1 Never Married 2 Married 1 Yes 2 No	Yes 2 No Specify:	nioun, etc.,		
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pm	7.	n na	Completed	(Specify only highest grade completed) (Give kin	nd of work done during most of workir O NOT use retired)	ng 161	o. Kind of Business/In-	dustry
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2;55	nd	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name			
3	Σ	should I	Ţ	Paul Eugene Takayaki Honda		Arlene I		
	Maryland 21215-0036	d 2 sh th and 7 lan traun			Address (Street and Number or Rura. Ch Ct., Port Dep		ity or Town, State, Zip 21904	Code)
1	ē,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 Ia marked other than "natural", or Itams 23a or 28a-1 show any injury or other traumatic event. The Medical Exprise or timest be rediffed at angle injury or other traumatic event. The Medical Exprise or timest be rediffed at angle injury.		20a. Method of Disposition  1 Rurial 2 Micromation 3 Removal from State  20b. Place of Disposition  cemetery, cremati			Location - City or To	own, State
5	E O	8°= 5		1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State R. A. Fer		05 We	st Chester	, PA
4130/05	Baltimore,	permit. Pag Department Important: any injury once.		21. Signature of Funeral Service Licensee	Name and Address of Facility	ral Homo	το λ	
m	<u> </u>	88 = 88		Mua C. Bellman	Name and Address of Facility. Arring—Cargo Funei Derdeen, Maryland	21001-3	359"	
,				<ol> <li>Part1. Enter the disease, or complications that caused the death. Do not enter to shock, or heart failure. List only one cause on each line.</li> </ol>	the mode of dying, such as cardiac or	r respiratory arrest		Approximate Interval Between Onset and Death
		Physician /Medical		resulting in death)	hsis		8	days
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na	Box (	death certificat attending phy d for use as the	/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delive	IV.
1	Ä.	death e atte	Icia	in the past 12 months?  1 Ves 14 Pregnant at time of death 5 0	ctopic pregnancy Other <i>(specify)</i>		Month	Day Year
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2	Records,	nelaw hasl ge 2 s	Completed	Anemia Hematemesis		24a. Was an autopsy performed	prior to cor	osy findings available npletion of cause of
()	<u>a</u>	ificate or, pa		25. Was case referred to medical	26. Place of Death	1 Yes 2	No 1 ☐ Yes	2 No
	of Vital	yaicile is ceri	To Be	examiner? 1 ☐ Yes 2 2 60 Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatient	Others		a 6 □Other (Specifi	·)
8	0	ng Ph fter th neral		27. Manner of Death 1 Natural 5 □ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury		8d. Describe how		
0	Sio	tendli leath. tor: A the fu	catle	2 Accident investigation	M 1 Yes 2 No			
29	Division	or At after o Direct in by	ertiflcation:	4 Homicide  4 Homicide  4 Homicide  4 Respective to the state of the s	, factory, office 2	8f. Location (Stree City or Town, S	t and Number or Rura tate)	l Route Number,
~	_	To the Hospital or Attending Physician: The law requires that the death certifical within 24 hours after death.  To the Funeral Director: After this cellificate has been signed by the attending phycompletely filled in by the funeral director, page 2 should be detached for use as the	O	29a. Certifier Certifying Physicien: To the best of my knowledge, death or	ccurred at the time, date and place, a	nd due to the caus	e(s) and manner as st	ated.
		n 24 h	edical	(Check only 2 Medical Exeminer: On the basis of examination and/or invesore) and manner stated.	itigation, in my opinion, death occurre	d at the time, date	and place, and due to	the cause(s)
		To the comp	Ž	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month,	
				▶ Bzig MIRZA A-BAIGMI			ay 1,2005	
		10		30. Name and address of person who completed cause of death (Item 23a) (Type, Print 515. S. Liman Ave. Mav.	re de Grace	, MD	21078	2
		Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature				
		Registr	ar	MAY 1 3 2005 Block				

			For State Registrar	State of I	Marylan		artment				lental Hyg	jiene ()	05	16344
			1. Decedent's Name (First, Middle	, Last)							2. Date of Dea Month	th Day	Year	3. Time of Death
	Physici /Medic		DOROTHY	ANN	THO	MPSON					APRIL		05	11:15 P M
	Examin	er	4a. Facility Name (If not institution,	-	er)		4b. City, 1		Location				y of Death	
			6413 COFFMAN FA						DYSV.					INGTON
	Funeral			6. Sex 7.	Age (In yrs.	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Birth (Month, Day JULY 27	Year)	9. Birth	place (State or Foreign intry)
	Director		236-66-1672 Usual Residence of Decedent			113.					JULY 27	, 1943	WŁ	EST VIRGINIA
	land ow		10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits
	Mary F sh	ğ	MARYLAND WASI	HINGTON				KEE	DYSV	[LLE				1 ☐ Yes 2 🖸 No
	1 the	Je C	10e. Street and Number				10f. Zip	Code			1	0g. Citizen of	What Cou	untry?
	ath with the Marylan s 23a or 28e-f show	Funeral Directo	6413 COFFMAN FAI	RMS ROAD					21756	ó			U.S.	Α.
	deati	ner	11. Marital Status	12. Was Decede Armed Force		.S. 13.	Was Deced				ecify Yes or No- Rican, etc.)	14. Ra	ce - Amer	ican Indian,
٥	or Ite		1 ☐ Never Married 2X Marri				1 ☐ Yes 2		Specify:		rilouri, oto.,	Speci	ack, White	, etc.
5-0036	hours tural',	d by	3 Widowed 4 Divorced	Year or Date	s:		- 15							WHITE
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מ	filed Hygi other	ပ္	17. Father's Name (First, Middle, I	_ast)							(First, Middle, i			11.3
Maryland	9 E 5 S	To Be	FILMORE H. DAV	ΓS					MARO	TE N	MARIE AT	KINS		
<u></u>	2 should to and Ment Is marked	F	19a. Informant's Name/Relationsh			19b. Mailir	ng Address	(Street a					, State, Zi	ip Code)21756
Ĕ	5 # 7 E		CLAUDE R. THOMPS	SON JR/SPOU	JSE						D, KEED			
ā,	- i i =		20a. Method of Disposition		1 0	Place of Dispo cemetery, crei	sition /Nam	ne of				20c. Location		
Ë			1 ☑ Burial 2 ☐ Cremation  1 ☑ Donation 5 ☐ Other (Sp		119	-			1	)4/2.7	/2005 F	ROWNSV	TLLE	MARYLAND
Baltimore,	permit. Page Department of Importent: If any injury or once.		21. Signature of Funeral Service	icen ee Doug		22	. Name and	d Addres	s of Facili	ty .	7606 01d			
n	8 3 3 6 5		and My	Paul Paul	M. De	an BA	ST FU	INER <i>P</i>	T HO	ME ]	Boonsbor	o, Mar	yland	d 21713
			23a. Part 1. Enter the disease, or shock, or heart failure. List	complications that caus only one cause on each	h line.									Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	Chr	mic i	obst	ruct	ite	pu	lmo	nary &	J'fes	20	Onset and Death
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VIII a	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othe			(Check only on			
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	ding h. h. After funer	tion	1 Natural 5 Pending 2 Accident investig		Day Yeer)	Injury	м	Bc. Injury Work 1 ☐ Y	:?ົ ∕es 2.⊟	- 1		.,,		
Nision	Attending r death. ector: After by the fune	fica	3 ☐ Suicide 6 ☐ Could n	ot be 28e. Place of	Injury - At ho	pme, farm, str	eet, factory,	, office					ber or Rur	al Route Number,
5	s after	Certification:	4 ☐ Homicide	building,	, etc. (Specif	y)					City or Towr	n, State)		
	To the Hospitel or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical (		g Physician: To the be Examiner: On the basis and manner	s of examina									
	To the within 2 To tha complet	Me	29b. Signature and title of certifier				29c.	. License	number	_	2	9d. Date signe	ed (Month,	Day, Year)
			) Q1	4= 4 ml				D2	145	7		4-25	5-2	.005
5H	1-8		30. Name and address of person of ABOUL WAY	who completed cause of	of death (Item	n 23a) (Type,	Print)	141	(A)	炬.	HAGER	Stown	r. 11	021742
	Sta Registr		31. Date filed (Month, Day, Year)		istrar's Signa		realist					• •		
				1										

			1 - For Stete Registrer	State of Marylar		artment of F			giene Reg. No.	2005	
	Physici /Medio Examir	cal	Decedent's Name (First, Middle, Last)     Roland     Aa. Facility Name (If not institution, give state)	H. Tancl	ς	4b. City, Town, or	r Location of	2. Date of Dea Apr. 26	, 2°00	5 Year	3. Time of Beath U
	Funeral Director	lei	National Luth  5. Social Security Number 6. Sec	eran Home	last birthday) Yrs.	Rockv If Under 1 Year Months Days			Мо	ntgome	ery lace (State or Foreign try) Consin
	Maryland a-f show	tor	Usual Residence of Decedent  10a. State	omery 10c. Cit	y, Town or Lo Ro	ocation OCKVille	<u> </u>				0d. Inside City Limits  X□Yes 2□No
	th with the 23a or 28 ust be not	Funeral Director	10e. Street and Number 9701 - Veirs Dr	ive		10f. Zip Code	20850		-	n of What Coun USA	try?
900	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Exactification and once.	þ	11. Marital Status  1 □ Never Married 2 □ Married  ★□ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: WW	)	. 37	lispanic Origi an, Mexican, Specify:	n? (Specify Yes or No- Puerto Rican, etc.)		. Race - Americ Black, White, o DecifyWhit	etc.
21215-0036	d within 72 h giene. Irre Madical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usual Occup kind of work done o DO NOT use retired 1010gist	during most of	of working Pr		of Business/Inc	
yland	ould be file Mental Hygarkad othe atic evant,	To Be C	17. Father's Name (First, Middle, Last) Gustav Tanck				Ma	s Name (First, Middle, aria Kueh	n		
Baltimore, Maryland	f and 2 sho fealth and om 27 is mu		19a. Informant's Name/Relationship (Ty, Carol Tanck-Dau	ghter	11905			or Rural Route Numbe  Dr., Roc  Date	kvil	le,Md.	20854
Itimor	it. Pages rtment of h rtant: If ite njury or ot		20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □ R  4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service License	emoval from State Meti	emetery, crei	natory or other place Ltan Cre	i	cy-4/30/0	5-A1	tion - City or To exandr	ia, Va.
Ba	Depa Impo any i	9. 9	23a. Part1. Enter the disease, or compli	cations that caused the deat		Hysong	Co.,	[nc.	sh.,	DC	Approximate
	Examine be executed // // // // // // // // // // // // //	Examiner	shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as a conseq	uence of):  Ug	SRAHYTI SATIRY	Olst	OI SUMILE			Interval Between Onset and Death
P.O. Box 68760,	The law requires that the death certificate be executed the has been signed by the attending physician and hage 2 should be detached for use as the burial-transit	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	I. 3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	death 3	Ectopic pregnancy Other (specify)			230	Date of deliver     Month	ry Day Year
	w requires that been signed should be det	by	Part II. Other significant conditions con	tributing to death but not res	ulting in the u	nderlying cause give	en in Part I.		bacco use es 2⊠1		e cause of death? ably 4 Unknown
al Reco		Completed						24a. Was a autops perform	sy med?	prior to com death?	osy findings available apletion of cause of
Division of Vital Records,	To the Hospital or Attanding Physician: The within 24 burns after death.  To the Funaral Director: After this certificate ha completely filled in by the funeral director, page	ation; To Be	25. Was case referred to medical examiner?  1	ospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time of Injury	28c. Injun Work	er: 4 🗷 Nurs	of Death (Check only or ling Home 5 Reside 28d. Describe he	ence 6		)
Divis	ospital or Attand hours after deatt unaral Diractor: ly filled in by the	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, str	eet, factory, office		28f. Location (Si City or Town		lumber or Rural	Route Number,
	To the Hospital or Al within 24 hours after of To tha Funaral Dirac completely filled in by	Medical	(Check only 2 Medical Examir one)	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, death tion and/or in	vestigation, in my or	pinion, death	occurred at the time, d	late and pla	ace, and due to	the cause(s)
0	7 ¥ 5 2	-	29b. Signature and title of certifier  Note:  30. Name and address of person who co	mpleted cause of death (Item	1 23a) (Tyne	Print)	5115	8	APRI	igned (Month, D	
K	Sta	te	VATTI-T- Proptomy 31. Date filed (Month, Day, Year)	9701 VEIN	ture_	100	ROCK	ulle t	102	0850	
	Registr		MAY 0 2 2005	Glow &	Los	Be					

			1 - For State Registrar	State of Maryla	ind / Depa			•	ygiene	105	16346
			Registrar     Decedent's Name (First, Middle, Last	)	Cei	unicate or	Dealii	2. Date of D	Reg. No.		3. Time of Death
	Physici		Glenda Ann Wh					April		2005	5:15PM M
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Death			County of Death	
			16911 Shinham	Rd		Hage	erstown		Wa	shinata	on County
	Funeral		Social Security Number     6. Se     1	X 7. Age (In yr.	s. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of B	lirth Day, Year)	9. Birtho	lace (State or Foreign
	Director		235-66-8802 Usual Residence of Decedent		61 Yrs.			Sept	26 1	943 Wes	sť Virgin:
	yland Jow		10a. State 10b. County	10c. (	City, Town or Lo	cation				1	0d. Inside City Limits
	a-fat	ctor	Maryland Washi	ngton	Ha	gerstow	n				1 ☐ Yes 2 No
	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citiz	en of What Cour	itry?
	be filed within 72 hours after death with the Maryland ntal Hygiene. so other than "natural", or Items 23a or 28a-f show evant, the Modical Examiner must be notified at	ral	16911 Shinham			217				ed Stat	
	Item Item	Funeral	11. Marital Status  1 ☐ Never Married 2 🕱 Married	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of H f Yes, specify Cuba	ispanic Origin? (Spann, Mexican, Puerto	ecify Yes or N Rican, etc.)	10-	<ol> <li>Race - Americ Black, White,</li> </ol>	
936	urs af	by F	3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 <b>X</b> No If Yes, Give Year or Dates:		I□Yes 2∭XNo	Specify:			Specify: V	White
9	72 ho	ted	15. Decedent's Edu (Specify only highest grad	cation	16a. Dece	lent's Usual Occup	ation		16b. Kin	d of Business/Inc	dustry
2	ithin ne.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	OO NOT use retired	during most of worki	ing			
121	filed w Hygier other th		12 17. Father's Name (First, Middle, Last)		Ho	nemaker	40.14.15.4.15.	/FT	Per	sonal I	Residence
anc	ould be fi Mental H arked ot atic evar	Be					18. Mother's Name				
Maryland 21215-0036	should nd Me mark matic	7	Edward Martin  19a. Informant's Name/Relationship (7)	rpe, Print)	19b. Mailir	n Address (Street	Beul and Number or Burs	an Di	velb.	liss Ma Town State Zin	artin <sup>Code)</sup> 21740
	permit. Pages 1 and 2 should be f Department of Health and Mental I Important: If item 27 is marked of any injury or other traumatic eva		William R.Whe		and)	16911 SI	ninham R	d. Ha	gers	town Ma	21740
Baltimore,	is 1 a		20a. Method of Disposition	20b.	Place of Dispo			Date		ation - City or To	
Ē	Page nent c int: If		1 ☐ Burial 2√ Cremation 3 ☐ F  1 ☐ Donation 5 ☐ Other (Specify)	Removal from State			atory 4-2	5-05	Smi	thsburg	Maryland
a II	permit. Departn Imports any inju		21. Signature of Funeral Service Licens			. Name and Addres					cal Home
<u>m</u>	89 2 2 3		Douglas a.	Lucy			n Blvd. N	I. Hage	erstow		
	<u> </u>		23a. Part1. Enter the disease, or compleshock, or heart failure. List only of								Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition resulting in death)	Metastate	ec Squ	lancus	Cell Co	MICET	Ve C	ince	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conse	equence of						
		e.	Sequentially list conditions,	Due to (ur as a conse	equence of).						
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events								
o,	te be executed ysician and ie burial-transit	Еха	resulting in death) Last	Due to (or as a conse	equence of);						
3760,	4 4	Ical		1							
ر 68	leath certificat attending phy I for use as th	by Physician/Med	IF FEMALE:								
) ô	ath ce	ian/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe	tal death 3 [	Ectopic pregnancy			23	d. Date of delive Month	ry Day Year
40	0 0 0	ysic	1 ☐ Yes 2 No 9 ☐ Unknown	4☐Pregnant at time of 9☐Unknown	death 5□	Other (specify)			ļ	World	Day Teal
00	The law requires that the site has been signed by the bage 2 should be detached.	/ Ph	Part II. Other significant conditions cor	ntributing to death but not re	sulting in the ur	iderlying cause give	en in Part I.	23e. Did	tobacco us	e contribute to th	e cause of death?
Sp	ures signa Id be	d b	Diaters ME	Mitus 2:	Orca	* 10	least	1 🗆	Yes 2	No 3□Proba	ably 4 Dunknown
<b>₹</b>	w requir	lete	Dicanca, T		- 111	is listic	Salar	24a. Wa	san	24h Were autor	sy findings available
ME/0/k al Records,	The lav	Completed	2/11/2/201	Tans Delis	1019	eures	15170	auto perf	opsy ormed?	prior to con death?	pletion of cause of
ital	ian: rtifica tor, p	a	25. Was case referred to medical	na presia			26. Place of Death	1 Yes	one)	1 🗆 Yes	2 No
£ >	Physician: r this certific ral director,	ToB	examiner?	fospital: 1 Inpatient 2	☐ ER/Outpatien	t 3□ DOA Othe	er: 4 Nursing Hor			☐Other (Specify	)
20	ng Pt fter th	:uo	27. Manner of Death  Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at 2	28d. Describe			
所X Division of	Attending r death. ector: After by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be				Yes 2□No				
Σ	l or Attsn after deat Director: in by the	it it	4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, stre cify)	et, factory, office	2	28f. Location City or To	(Street and own, State)	Number or Rural	Route Number,
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page		29a, Certifier Certifying Phys	sician: To the best of my kr	nowledge death	occurred at the tim	on date and place of	and due to the	20000(0) 0	nd manner so etc	and i
	24 h	edical	(Check only 2 Medical Exami	ner: On the basis of examinand manner stated.	nation and/or inv	estigation, in my or	pinion, death occurre	ed at the time	, date and p	lace, and due to	the cause(s)
_	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. License			29d. Date	signed (Month, D	Pay, Year)
			Villay E. Wa	my do		DZ:	3815		4.	26 - 2	005
			30. Name and address of person who co	empleted cause of death (Ite	em 23a) (Type, I	Print)	1 1			^	
ت	4-12		0.1017 -	neg, 354	Will	Stree	r, Has	21570	own,	1118)	21740.
	Sta Registra		31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature	with	V				
	i icgisti	-11	ALIK W. E	1	- //						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend i ten 10e per fly 843 5-13 05 avt Mental Hygiene For State Registrer Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 0901 CLEM WEISS 2005 CHARLES may /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Upper Chesapeake Medical Center Bel Harford 6. Sex 1 M 2 ☐ F If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 3/26/1920 85 Yrs. Director 218-18-7905 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No MD. Harford Jarrettsville 10e. Street and Numb**Rigdon** 10f. Zip Code 10g. Citizen of What Country? 21084 1358 Ridgon Road United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Quality Control Inspector Aircraft 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be fill and Mental H Charles Werner Weiss Jane Louise Doged 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If itam 27 is m any injury or other traum 000e. Theresa G. Weiss /Wife 1358 Rigdon Rd. Jarrettsville, Md. 21084 20a. Method of Disposition
1 ☐ Burial 2 ★Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Carroll Cremation 5/9/2005 Hampstead, Maryland ¹ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Jarrettsville, Maryland lusten E.G. Kurtz & Son Funeral Home, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ACUTE HEMORRHAGIC STROKE (MASSIVE) **Physician** disease or condition resulting in death) 1 DAY /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consecuence of Examiner the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ATRIAL FIBRILLATION, HYPOTHYROLD 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? Vital 2□ No 1 🗆 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 X No ð After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To ha Funaral D cor pletely filled it the Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Malleyou D45344 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 622 S. UNION ALE HAVRE DE GRACE, I D 21076 SURE H DI ANTANI, MO

Registrar

DHMH 17 Rev 1/2001

State

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CHARLES

32. Resistrar's Signature

		•	1 - For State Registrar	State of M	aryland		artment rtificate				Reg. No.	05 16348
· A	Physici	an	1. Decedent's Name (First, Middle	Last)						2. Date of De Month	Day 17	Yea US 172 M
	/Medic	al	SEYMOUR  4a. Facility Name (If not institution,	WOLF	)		4h City T	own or Loc	ation of Death	1	4c. County o	of Death
	Examir	ier		UMA CEN			Λ.	TIMO	_			ore City
Ħ	Funeral		5. Social Security Number	6. Sex 7. Ac	ge (In yrs. la	st birthday)	If Under 1	Year If	Under 24 Hrs. ours Min.	8. Date of Bir (Month, Da		Birthplace (State or Foreign Country)
615	Director		107-16-3547	10XM 2□F	83	Yrs.	Mortins	Days II	ours Min.	07/26/1		New York
	and		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	ocation					10d. Inside City Limits
	Marylan f show	ō	MD Anne A	rundel	Annaj	polis						1 X Yes 2 No
	r 28a	lrec	10e. Street and Number			-	10f. Zip 0	Code			10g. Citizen of W	hat Country?
	th with	Funeral Director	1 Market Quay				214	01			United S	tates
	er dea	uner	11. Marital Status	12. Was Decedent Armed Forces	?		Was Decede If Yes, specif	ent of Hispa ty Cuban, M	nic Origin? (Si lexican, Puert	pecify Yes or No o Rican, etc.)	14. Race Black	- American Indian,
36	s afte	by Fu	1 ☐ Never Married 2 ☐ Marri 3 🛛 Widowed 4 ☐ Divorced	ed 1 1√2 Yes 2 □ If Yes, Give Year or Dates:	No WW	II	1 ☐ Yes 2	No Si	pecify:		Specify:	White
215-0036	be filed within 72 hours after death with the Maryland ital Hyglene. d other than *natural', or items 23a or 28a-f show event, I're Medical Examinar must be rotified at	led t	15. Decedent	's Education			dent's Usual				16b. Kind of Bus	siness/Industry
215		pje	(Specify only highes Elementary/Secondary (0-12)	t grade completed)  College (1-4or	5+)	(Give life.	kind of work DO NOT use	done durin e retired)	g most of wor	king		
2	filed wit Hygien other th	Completed		5+		Chair	man/C		Executi		Manufac	
ng	be fill Hall Hall Hall Hall Hall hall off	Be	17. Father's Name (First, Middle, I Abraham Wolf	_ast)							, Maiden Sumame	9)
Maryland	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the M	ပ္	19a. Informant's Name/Relations	nin (Tyne Print)		19b Maili	nn Address /		ora Hei Number or Ru		er, City or Town, S	State. Zin Code)
Ma	s 1 and 2 should I Health and Men Item 27 is marke other traumatic		Douglas M Wolf							oac, MD	alesta con	,
ē,			20a. Method of Disposition			ace of Dispo	osition (Name matory or oth	e of	L C LOL	Date PIL		City or Town, State
Baltimore,	0 0		15 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Si	3 □Removal from State	•	-	ld Mem		04/2	29/2005	Falls C	hurch, VA
alti	permit. Page Department of Important; If any injury or		21. Signature 1 meral Service	Designe   D	11-	2:	2. Name and	Address of	Facility			
	20 = 20		12 0 les	In Mym	and OF							ring, MD 20904
	Physician /Medical		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a. Substitute of the following carrier on the cause on each of the cause on each of the cause of	ine. )URAL	<i>+</i>	IEMA	_		or respiratory a	rrest,	Approximate Interval Between Onset and Death
В	Examiner	10	Sequentially list conditions if any, leading to immediate	b. FALL Due to (or as	OUT	OF	BED	)				1 DAY
	uted Insit	Examiner	cause. Enter Underlying Cause (Disease or injury		o a oomooqa	31100 017.					211	
ó	te be executed ysicien and se burial-transit		that initiated events resulting in death) Last	C. Due to (or as	s a conseque	ence of):				1	7111	
1760,	÷ × ×	Cal		d						~ 1 A	- K 1/1/K	
<b>68</b>	artifica ing ph e as th	Med	IF FEMALE:							1) 10	1 July	
Box	Physician: The law requires that the death certificat this certificate has been signed by the attending phyral director, page 2 should be detached for use as the	Completed by Physician/Med	23b. Was decedent pregrant in the past 12 months? 1 □ Yes 2 ☑ No	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Fetal	death 3[	⊒Ectopic pre ⊒ Other <i>(spe</i>			Al John	MED 230. Date	e of delivery oth Day Year
P.0	by the	hys	9 Unknown	9□ Unknown					XV	PPROV		
	es tha	by F	Part II. Other significant condition	_		-	inderlying ca	use given ir	Part I.			bute to the cause of death?
ord	w requir been si should	ted	ATRIAL FIBRILL	ATION, ON C	OUMAD	1N				-		3 Probably 4 Unknown
Records,	has b	mple								24a. Was auto perfe	psv / pi	Vere autopsy findings available rior to completion of cause of eath?
Vital	ysician: The lavis certificate has director, page 2		25. Was case referred to medical					26	Place of Dea	1 ☐ Yes		☐ Yes 2☐ No
<u>&gt;</u>	ysicia s cert direct	To Be	examiner? 1 ☑ Yes 2 ☑ No	Hoenital:	tient 2 E	F/Outpatie	nt 3 DO	Other			idence 6 □Othe	or (Specify)
ιof	ding Phys. After thi funeral		27. Manner of Death	28a. Date of Inj (Month, P	jury av Year)	28b. Time o	of 28	3c. Injury at Work?		28d. Describe	how injury occurre	be
Ö	Attending r death. sector: After by the fune	atlc	1 Natural 5 Pendin 2 Accident investig 3 Suicide 6 Could	gation 4/26/C	25	, , , ,	М	1 🗆 Yes	2 No	FALL	OUT OF	BED
Division	or Att	Certification:	3 Suicide 6 Could in determined	building, e	etc. (Specify)	me, farm, st )	reet, factory,	office		City or To	wn. State)	er or Rural Route Number, วงฯยเ
	pital ours a aral [	I Ce	29a. Certifier 1 Certifyin	g Physician: To the bes	_	viedoe des	th occurred o	at the time	tate and place	1 MMLE		ANNAPOLIS, MD
	To the Hospital or Attending Ph within 24 hours after death. To the Funaral Diractor: After th completely filled in by the funeral	edical	(Check only 2 Medical one)	Examiner: On the basis and manner s	of examinati	on and/or in	ivestigation,	in my opinio	on, death occu	irred at the time.	date and place, a	and due to the cause(s)
	To th within To the	Me	29b. Signature and title of contrie					License nu	ımber			(Month, Day, Year)
			<b>)</b> ///	M/n	$\wedge$		1	5114			4/27/	05
	10		30. Name and address of person						_			
			28 S. GREEN	VE ST	BA	LTIM	ORE,	WD	21201			
	Sta Regist	ate rar	31. Date filed (Month 2) Year	9 2005 32.	trar s Signati	A. A	bede	9	21201			

State of Maryland / Department of Health and Mental Hygiene 1- State Amend Item 2 per dvr G843 5-17-0 first are of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **2005 Physician** ROLAND ANDFRSON /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NORTHWEST HOIP ITAL JDAMS TOWN BALT/MURGE 8. Date of Birth Moeth, Day Y 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 219-52-7720 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Madical Examiner must be notified at Ba Battimor 1 Nes 2 No Completed by Funeral Director Maryland 10e. Street and Number 10g. Citizen of What Country? 9 3505 or itams 23a 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ res 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Tyes 2 No f Yes, Give Year or Dates: 3 Widowed 4 Divorced "natural", 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: if tiem 27 is marked other then "ne eny injury or other traumatic ave." (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary ( College (1-4or 5+) Electrician Grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 505 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death DNEWMONIA Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner DEFICIENCY ACQUIRED IMMUNTE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed as the burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 🗆 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 10 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 ER/Outpatient 1 Inpatient 3□ DOA in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28b. Time of 28c. Certification: 28d. Describe how injury occurred After 5 Pending investigation 1 Natural 2 Accident after death. 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manne 29b. Signature and tille 29c. License number 29d. Date signed (Month, Day, Year) D43491 2005 ause of death (Item 23a) (Type, Print) 5401 MILMEL RUTHKIN RUAD OUD COURT 21133 31. Date filed (Month, Day, Year) 32 # gistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item/12, perFH, 6343,5/27 (05 11 State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Frederick George Albers, Sr. a M 05 95 11:40 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Rosedale

| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | April 25, 1925 Ba / timore Franklin Square Hospital Center
5. Social Security Number 6. Sex 7. Age (In yrs. la 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1**X** M 2□ F Yrs. 219-16-5695 80 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County in then "neturel", or Items 23a or 28e-f show the Medical Examinar must be notified at 1 ☐Yes 2 No Funeral Director Perry Hall Baltimore Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4259 B Chapel Road 21128 U.S.A. Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hyglene. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? WIII 1 XYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) WII 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: Be Completed by 3 ☐ Widowed 4 ☐ Divorced 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Quality Control Martin Marietta 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Albers George Jeanette H. Koehler 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Importent: If item 27 Is eny Injury or other tre once. Mrs. June A. Knight (wife) 4259 B Chapel Rd., Perry Hall, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State permit, Page Department of 5 Other (Specify) Bayview Crematory 5/14/2005 ` 4 □ Donation Baltimore, Maryland 21. Signature of Juneral Service Lic 22. Name and Address of Facility Schimunek Funeral Homes 9705 Belair Rd., Baltimore, MD 21236 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician ardiojenic Shock 4 hours /Medical Due to (or as a confequence of): Examiner cardiomyopathe hemie if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit To the Hospitel or Attending Phyeicien: The law requires that the death certificate be executed Multiple MI Due to (or as a consequence of): Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 12 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 2 ER/Outpatient 3□ DOA this 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide within 24 hours a
To the Funerel C
completely filled 10x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signarure and title of certifie 29c. License number 5-13-65 0 who completed cause of wath (Item 2. Klin Square Drive Baltimore, Md 21737 Registrar's Sign Registrar

		1 - State Registrar		Ce	rtificate of	Death		Reg. No U U	635
Physici	an	1. Decedent's Name (First, Middle, Last) Salvatore Francis	Angelozzi				2. Date of De	Day Yea	3. Time of Death 5 12:10 A
/Medio Examir		4a. Facility Name (If not institution, give s			4b. City, Town, o	r Location of Death	MAY	10, 200 4c. County of De	
		Good Samarita				more		NA	
Funeral Director		5. Social Security Number 6. Sex 1218-32-2719	[14 0   F	n yrs. last birthday) 88 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bill (Month, Da Decembe	er 24,1916	irthplace (State or Fore Country) Maryland
land		Usuaf Residence of Decedent 10a. State 10b. County	11	Oc. City, Town or Lo	ocation				10d. Inside City Lim
a-f sh	ctor	Maryland Baltimor	re	Parkvi	11e				1 □ Yes 2 📉 1
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, it is Medical Exaginate cust be invitited at Once.	Director	10e. Street and Number 8832 Walther Blvd.			10f. Zip Code 21234			10g. Citizen of What C United St	
death	Funerai		12. Was Decedent Eve Armed Forces?	er in U.S. 13.		lispanic Origin? (Span, Mexican, Puerto	ecify Yes or No		nerican Indian,
rs after i', or ite	by Fu	1 ☐ Never Married 2 ☐ Married 3 🖫 Widowed 4 ☐ Divorced	1 X Yes 2 □ No If Yes, Give Year or Dates: W		1 ☐ Yes 2 📉 No	Specify:	riloan, otc.,	Consitu	hite
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within ane.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	d)	9	construc	tion
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lth and 27 is m		19a. Informant's Name/Relationship (Type Clare MacDonald/data	•		ng Address (Street est Side 1			er, City or Town, State Seach, DE	19971
of Hea		20a. Method of Disposition 1XBurial 2 ☐ Cremation 3 ☐ R		20b. Place of Dispo cemetery, cre	osition (Name of matory or other place	(өэ	Date	20c. Location - City of	or Town, State
t. Pagi tment rtant: I		*4 ☐ Donation 5 ☐ Other (Specify)				tery May 1			Maryland
permi Depar Impo any ir		21. Signature of Funeral Service License	Golf X	2:	Name and Addre Mitche 6500	e11-Wiede:	feld Fu	neral Home more, MD	Inc.
		23a. Part1. Enter the disease, or compli- spock, or heart failure. List only on	cations that caused the	e death. Do not en	ter the mode of dyir	ng, such as cardiac	or respiratory a	rrest,	Approximate Interval Between
Pnysician		Immediate Cause (Final disease or condition resulting in death)	Aspira	tion of	- blood	/			Onset and Death
/Medical Examiner			Projector	consequence of):	vic he	morrh	992		
ם יו	aminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a c	onsequence of):					
executed and al-transit	Exam	that initiated events resulting in death) Last	Due to (or as a c	onsequence of):					
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ding pt	/Med	IF FEMALE:	3c. If yes, outcome of	oregoancy				and Date of d	
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aw req s been 2 shou	Completed by	Mesenteric Steno				2	24a. Was		autopsy findings availal
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siclan: certific irector,	Be	25. Was case referred to medical examiner?	lospital:	2 🗆 🗆 🗆	oth	26. Place of Death			
g Physier this	n: To	27. Manner of Death	28a. Date of Injury (Month, Day Y	2 ER/Outpatie 28b. Time o lnjury	IL 3 DOA	4   Nursing no		idence 6 Other (Sp how injury occurred	ecity)
tendin leath. tor: Af the fur	catio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be			M 1 🗆	Yes 2 □ No	006 1	(Charles 11)	
after d Direct	Certification:	4 Homicide determined	28e. Place of Injury building, etc. (	- At home, farm, st 'Specify)	reet, factory, office		City or To	Street and Number or I wn, State)	Rural Route Number,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical C	29a. Certifier 1 Certifying Phys	sician: To the best of r	ny knowledge, deat	h occurred at the tir	me, date and place,	and due to the	cause(s) and manner a	as stated.
o the hithin 24 o the Formplete	Medi	29b. Signatute and title of certifier	and manner stated	d.	1 40 15			001.0	
F 3 F 8		> lych of	(M)		D6	0539		Mail	3.2005
ıΛ		30. Name and address of person who co	mplete cause of deat		Print)	( )	115 0	May 1	
		VIIIN HEADE 66	ul woon 1	ravel 6	Iva Gal	TIMORE,	VIU Z	1404	
∫() Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's						

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amend item#20b-c.perFH G8/43, 5/16/05 TT
State of Maryland Department of Health and Mental Hygiene

1- state amend items 5,8 per fh g8/44 6-2-05 cate of Death

Reg. No. 2 [] [] 5 1. Decedent's Name (First, Middle, Last) 2. Date of Death 200 5 **Physician** COLUMBUS BROWN MAY /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** BALTIMORE NA BALTIMORE VA HOSPITAL 226al Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth 931 (Month, Day, Year) **Funeral** Hours Months Days Min. 1 ■ M 2 □ F <del>233</del> 32 6708 13 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov traumatic event, the Medical Examiner must be notified at 1 Yes 2 No BALTIMORE NIA Directo MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with ō 21223 .200 N. PAYSON STREET USA or Items 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. XYes 2 □ No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No Specify: Specify: BLACK Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates "naturel" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d 2 should be filed within the and Mental Hygiene.
7 Is marked other then " Elementary/Secondary (0-12) College (1-4or 5+) SELF EMPLOYED HOME IMPROVEMENT NA 6/14 GRADE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be WILLIE BROWN LAURA LOGAN 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 432 S. CHAPEL GATE LN., BALTO. MD 21229 Pages 1 and 2 ment of Health a ent: If item 27 is ury or other tra SHEILIA GREEN 20b. Place of Disposition (Name of comptent, crematory crother place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Crownsy 11 Department of Importent; If eny injury or once. \* 4 ☐ Donation 5 ☐ Other (Specify) 05.18.05 MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility VAUGHN C. GREENE FUNERAL SERVICE auxn 5151 BALTO, NATE PIKE, BALTO, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPSIS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** CHOLECYSTITIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ρ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. the 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, page 2 should be NEOPLASM ANGREATIC 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an autopsy 1 ☐ Yes 2 No director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes No Certification: To in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. s after death 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel I filled Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 2 P/85 12,2005 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2/201 BALTIMORE, MD GREENE ST MARC BRAZIE 10 N. ogistrar's Signatur 6 32. 2005 State Registrar

215-12-0679   Col. Major   All Col. Col. Col. Col. Col. Col. Col. Co				1 - For State Registrar			of Mar	yland / Depa <i>Ce</i>	artment of F			Reg. No	15 16353
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Transfer Name (First, Middle, Master Sumane)   Transfer Name (First, M		and w					1	Oc. City, Town or Lo	ocation				10d. Inside City Limits
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### Part   Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.    Approximate friends   Approximate shock, or heart failure. List only one cause on each line.	, e	1 and Health em 27 ther to				Son		20b. Place of Dispo	osition (Name of				City or Town, State
### Part   Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.    Approximate friends   Approximate shock, or heart failure. List only one cause on each line.	JOE J	ages ant of ht: If it y or o		1 🕅 Burial 2	Cremation		om State	cemetery, cre	matory or other plac		10.05		
### Part   Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.    Approximate friends   Approximate shock, or heart failure. List only one cause on each line.	#	partm porter y injur	1					Contract to the second second			19-05	Lansdowne	, MD
Society of the part of the par	<u> </u>	88 2 2 8		Jan	uerta	Jones		V	Wylie Funera	al Home 63	8 N. Gilmo	r Street B	alto, MD 21217
Part				shock, or he	art failure. List	only one cause of	n each line.	4			,		Interval Between
Spanner of Death   Spanner of	£ .			disease or conditi	on	a F	NUE	MONIA					10 DAYS
FFMALE   23c. If yes, outcome of pregnancy   1   Live birth 2   Fetal death 3   Ectopic pregnancy   1   Live birth 2   Fetal death 3   Ectopic pregnancy   Month Day Year   1   Year 2   No 3   Probably 4   Driknown   Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II.   23c. Did tobacco use contribute to the cause of death?   1   Year 2   No 3   Probably 4   Driknown   Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II.   1   Year 2   No 3   Probably 4   Driknown   Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II.   1   Year 2   No 3   Probably 4   Driknown   Part III. Other significant conditions contribute to the cause of death?   1   Year 2   No 3   Probably 4   Driknown   24a. Was an autopsy findings available prior to completion of cause of get a completion of cause of get and autopsy findings available prior to completion of cause of get and autopsy findings available prior to completion of cause of get and autopsy findings available prior to completion of cause of get and autopsy findings available prior to completion of cause of get and autopsy findings available prior to completion of cause of get and autopsy findings available prior to completion of cause of get and autopsy findings available prior to completion of cause of get and autopsy findings available prior to completion of cause of get and autopsy findings available prior to completion of cause of get and autopsy findings available prior to completion of cause of get and autopsy findings available prior to completion of cause of get and autopsy findings available prior to completion of cause of get and autopsy findings available prior to completion of cause of get and autopsy findings available prior to completion of cause of get and autopsy findings available prior to completion of cause of get and autopsy findings available prior to com		- 14	dicai Examiner	that initiated eveni	lS	C	to (or as a c	ronsaculance of)-	ROTIC	KEAR	T <b>D</b> 13	(FASE	UNZ-NUNN
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The property of the property o	S, D	s mar gned b							inderlying cause giv	en in Part I.	23e. Did t	obacco use contr	ibute to the cause of death?
24a. Was an autopsy findings availably performed later to completion of cause of death?  24a. Was an autopsy performed later to completion of cause of death?  25. Was case referred to medical examiner?  25. Was case referred to medical examiner?  25. Was case referred to medical examiner?  26. Place of Death (Check only one)  27. Manner of Death  28a. Date of Injury  (Month, Day Year)  28b. Time of Injury  (Month, Day Year)  28c. Injury at Work?  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Location (Street and Number or Rural Route Number, City or Town, State)  29d. Date signed (Month, Day, Year)	ord	equire en sig	ted					リビルベケ			1 🗆	Yes 2□No	3 ☐ Probably 4 ☐ Unknown
1   Yes   2   No   1   Yes   N	Sec.	hasb pe2st	mple	1-6			<i>)</i> ∨ 				auto	psv p	rior to completion of cause of
To see that the second of the	alF	nt: In flicate or, pag		OF Mes ages rets							1 ☐ Yes	2 1 No 1	
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29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29b. Signature and date of certifier  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	Divis	s after des	Certific		determ	not be nined 28e. Pl	ace of Injury uilding, etc. (	- At home, farm, sti (Specify)	reet, factory, office				er or Rural Route Number,
29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  D 23300  MAY 14 2405  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  37 Name and address of person who completed cause of death (Item 23a) (Type, Print)		n 24 hour ne Funer oletely fills		(Check only	1 ☐ Certifyi 2 ☐ Medical	Examiner: On th	e basis of ex	camination and/or in	h occurred at the tin vestigation, in my o	ne, date and plac pinion, death occ	e, and due to the urred at the time,	cause(s) and mar date and place, a	nner as stated. Indidue to the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2nd 45/0 nd 18/03P.	i	To the company	Σ				W. Pm					-	* * * * * * * * * * * * * * * * * * * *
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12 h N 2 17 h D C 17 0 3 F.	,					100				2330	D	MAY	14 2005
DUDMIR, PATEL 2000W. BALTU ST. BALTU MAN. 21225		2		30. Name and add	ress of person	PATE	ause of deal 2	tri (item 23a) (Type, 2000 W	139L	35C0	nes h	270 1	11. 21225
31, Date filed (Month. Day, Year) 32. Registrar's Signature		Sta	ite			32	2. Registrar's	s Signature			,		
Pegistrar  DHMH 17 Rev 1/2001					MAY 1 8	2005	Mary	· K	back				
	DHM	H 17 Rev 1/2	001					ORIGIN					

arl	Brooks	5	Otata of Mandand / Da		•	_
			1- For Unpend Item 23a-B, pt.11,27,28a Registrar Amend Item 19b per fh G843 C	partment of Health and 18 ertificate of Death 5-1	dental Hygiei 8-05 tas <sub>eg.</sub> ,	2005 16354
			1. Decedent's Name (First, Middle, Last)		2. Date of Death	Day Year
	Physici /Medic		PEARL BROOKS			005 12:37 A <sup>M</sup>
	Examir	ner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
			Saint Joseph Medical Center  5. Social Security Number   6. Sex   7. Age (In yrs. last birthd.	Towson  If Under 1 Year   If Under 24 Hrs.	R Date of Birth	Baltimore State or Foreign
	Funeral Director		230 · 36 · 3477	Months Days Hours Min.	03.21.19	9. Birthplace (State or Foreign Country)
)	및		Usual Residence of Decedent		100 71 14	
	show	-	10a. State 10b. County 10c. City, Town or			10d. Inside City Limits 1 ☐ Yes 2 💆 No
	28e-f	ecto	MD BALTIMORE PARKVIL	10f. Zip Code	100	Citizen of What Country?
	be filed within 72 hours after death with the Maryland tial Hygiene. d other than "natural" or Itams 23a or 28e-f show avent, it s Madic. Examil or institutional.	Funeral Director	3 LYNFAIR CT. #T3	21234	, tog.	USA
	death ms 2	nera		Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - American Indian,
9	after or its	/Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 MENO	1  Yes 2 No Specify:	o rucan, etc.)	Black, White, etc.
21215-0036	hours ural',	d by	3 ☐ Widowed 4 ☑ Divorced Year or Dates:		1.0	Specify:BLACK
7	in 72 in 72	Completed	(Specify only highest grade completed) (G	cedent's Usual Occupation ive kind of work done during most of work e. DO NOT use retired)	king 166	. Kind of Business/Industry
212	d with giene.	mo	Elementary/Secondary (0-12)   College (1-4or 5+)   _	IMS REPRESENTAT		CIAL SECURITY
p	al Hygia I othar Ivant, I	BeC	17. Father's Name (First, Middle, Last) WNK		ne (First, Middle, Maid	en Sumame)
yla	should be nd Mental marked o	To T		ELIZABE	TH LEWIS	
Maryland	2 a si		19a. Informant's Name/Relationship (Type, Print)  JACK A. BROOKS, JR (SON) 8 9	ailing Address (Street and Number or Rui	ral Boute Number, Cit Ballti <b>mor</b> e	y or Town, State, Zip Code)
	1 and dealing am 2 than		OTICE IT BROOTE, SE CONS	MINIMARDE CITY	COOPERIOR	Location - City or Town, State
ğ	of of		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, of	crematory or other place)	10 · 05 BA	
Baltimore,	permit. Pag Department Importent: I any injury o					
B	Dep Per Siny		Mah Della	22. Name and Address of Facility VAUGHN C. GREENE F 5151 BAUO. NAT. PIKE	WHERAL SE	rvice no 21229
			23a. Party Enter the disease, or complications that caused the death. Do not shoot, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between
	Fnysician .		I and dista Course (Final	etroperitoneal Hemo		Onset and Death
	/Medical Examiner		regulting in death)	xternal Lliac Arte		ng Cardiac
B	LXGIIIIICI	e	Sequentially list conditions, if any, leading to immediate  b. Catheterization  Due to (or as a consequence of):	Procedure		
	nted I	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			
Ć.	te be executed ysician and te burial-transit	Examin	resulting in death) Last  C.  Due to (or as a consequence of):		-	
760,	# % e	ical	d			
68	The law requires that the death certificate to the has been signed by the attending physicage 2 should be detached for use as the board.	Physician/Med	IF FEMALE:			
Вох	ath ce	lan/	23b. Was decedent pregnant in the past 12 months?  23c. if yes, outcome of pregnancy 1 Live birth 2 Fetal death	3 Ectopic pregnancy		23d. Date of delivery  Month Day Year
o.	at the de by the a tached t	ysic	1 ☐ Yes 2 No 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 ☐ Unknown	5 Other (specify)	<del></del>	·
٣.	that I	by Ph	Part II. Other significant conditions contributing to death but not resulting in th	e underlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death?
rds	quires in sign uld be		Atherosclerotic Cardiovascular Disea	se	1 ☐ Yes	2 No 3 Probably 4 Unknown
Records,	aw requir s been si 2 should	Completed			24a. Was an	24b. Were autopsy findings available
		Com			autopsy performed	
Vital	Physician: Th this certificate al director, pag	Be	25. Was case referred to medical examiner?		th (Check only one)	
of \	Physic this of	ို	1 X Yes 2 No Hospital: 1 XInpatient 2 ER/Outpa	tient 3 DOA Other: 4 Nursing Ho	ome 5 Residence	6 ☐Other (Specify)
	ing After uner	tion	1 Natural 5 Pending (Month, Day Year) Injur	y Work?  M 1 Yes 2 XNo	Arterial	injury associated with
Division	I or Attanding after death, Diractor: After d in by the funer	fica	3 Suicide 6 Could not be 28e Place of Injury - At home, farm.		medical pi	and Number of Rural Route Number,
ē	al or A s after if Dira	Certification:	4 Homicide determined building, etc. (Specify)  Medical Center		Towson, M	
	To the Hospital or vithin 24 hours after To the Funeral Director completely filled in b		29a. Certifier (Check only (25) Medical Examiner: On the basis of examination and/o	eath occurred at the time, date and place,	and due to the cause	(s) and manner as stated.
	tha H hin 24 tha F mplete	Medical	one) and manner stated.			
	5 1 × 0 × 0	-	29b. Signature and title of certifier	29c. License number OCME		Date signed (Month, Day, Year)
,			20 Name and address of paragraphs applied a series (1)	no Bright	-	14 2005
			30. Name and address of person who completed cause of death (Item 23a) (Tyl	111 Penn Stree	et Baltimo	ore, Maryland 21201
	Sta	ite	31. Date filed (Month, Day, Year) 32. Signature	South 1		
	Registr	rar	31. Date filed (Month, Day, Year)  MAY 1 6 2005  32. Figistrar's Signature			

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Mayonth OP7 20°5 **Physician** 1:20 AMM Hazel Bavota /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner WORCESTER BERLIN NURSING & REHABILITATION CNT BERLIN If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday, **Funeral** 1□M Z Davs Months Hours Min Director SEPT 7, MD 91 214.14.5270 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-1 show traumatic event, the Madical Examiner was be notified at 1 ☐ Yes 2 ☐ No Director MD WORCESTER BERLIN 10g. Citizen of What Country? 10e, Street and Number 10f, Zip Code 10 238 9715 HEALTHWAY DRIVE USA 21811 Funeral or Itams 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. e filed within 72 hours after of Hygiene. Hygiene. other than "natural", or Ital 1 □ Yes **XX**No If Yes, Give Year or Dates: 1 Never Married 2 Married Bayota, Hazel Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: þ ₩Widowed 4 Divorced XXWHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) BOOKKEEPER LENMAR LACQUER 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should be fill tment of Health and Mental Hitant: If item 27 is markad other. Be CAROLINE FOUTZ 0 ALANZO DEMPSEY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10258 BENT CREEK CT OCEAN CITY MD 21842 JOAN PAUL DAUGHTER other 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State CRESTLAWN CEMETERY 5.12.2005 MARRIOTTSVILLE, MD parmit. Page Department of Important: If any injury or once. injury or Fineral Service License FINK FUNERAL HOME, P.A. 426 CRAIN HWY SW GLEN BURNIE, MD 21061 GREGORY FIN MO1148 ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part 1. Exter the disease, or con shock, or heart failure. List only pe cause on each line. Immediate Cause (Final disease or condition resulting in death) Pnysician heiner /Medical Que to (or as a consequence of): **Examiner** heroselerotic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be exacuted Due to (or as a consequence of) attending physician by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Por in the past 12 months? 1 Yes 2 No Month Day Year 4□Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown þ signad Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? should be 1 | Yes 2 | No 3 | Probably 4 Docknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed certificate 1 Yes 2□ No 2 Be

Box 68760, Division of Vital Records, P.O. or Attending Physician:

this

in by the funeral s after death.

fillad 24 hours a

within 2 To tha

25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: Nursing Home Certification: To 1 🗌 Yes 2 ER/Outpatient 3□ DOA 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the dause(s) and mainteness as account of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) icense number 29b. Signature 20 mpleted cause of death (Item 23a) (Type, Print) no della

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

**Signature** 

32. Registrar

		ľ	State of Maryla			t of H	ealth a		lental Hygi	ene g. No.20	05	16356						
	Physici	an_	1. Decedent's Name (First, Middle, Last)					2. Date of Death	Day	Year	3. Time of Death							
1	/Medic		GEORGE EDWIN BENTON						MAY 13,			2:35 P M						
	Examir	ier	4a. Facility Name (If not institution, give street and number)				Location o	f Death		4c. County	•	MDEI						
	Funeral	-		s. last birthday)	GLEN If Under	1 Year	If Under		8. Date of Birth (Month, Day,		E ARU 9. Birthp	NDEL Nace (State or Foreign ntry)						
	Director		219.36.1971		Months	Days	Hours	Min.	OCT 4,			MD						
	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f ehow ha Madigal Examirar mual be notiliad at	_	10a. State 10b. County 10c.	City, Town or Lo	ocation						1	0d. Inside City Limits 1 ☐ Yes 2 ☐ No						
	28a-f	Director	MD ANNE ARUNDEL I	INTHICU	10f. Zip	Code			10	g. Citizen of	What Cour	XX						
	with Ba or	ia	6313 HOMEWOOD RD			2109	n				USA	itty:						
	death ms 2:	Funeral	11. Marital Status  12. Was Decedent Ever in Armed Forces?	U.S. 13.				gin? (Spe	ecify Yes or No- Rican, etc.)	14. Ra	ce - Americ							
92	or ite		1 Never Married XXMarried Yes, Give		1 Yes X		Specify:	, rueito	racan, etc.)	Specia	ick, White,	etc.						
21215-0036	be filed within 72 hours after death with the Maryla stal Hygiene ed other than "natural", or items 23a or 28a-f ehov event, the Madical Examinar must be notified at	Completed by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	162 Dece	dent's Usua	d Occupa	tion			6b. Kind of E	WHI							
5	n "nai	plete	(Specify only highest grade completed)	DIREC	kind of wor	k done d	luring most	of worki	ing	MOTOR		,						
212	filed with Hygiene. Ither than	mo	Elementary/Secondary (0-12) Coilege (1-4or 5+)  12 4	DIREC	SERV			LAL				RATION						
ם	be filed htal Hygie ed other event, to	Be	17. Father's Name (First, Middle, Last)					r's Name	e (First, Middle, N									
yla	should be nd Mental marked o	2	GEORGE BENTON						E WATERS									
Maryland	S S B B		19a. Informant's Name/Relationship (Type, Print)  CATHERINE BENTON WIFE		-				I Route Number, THICUM,			Code)						
	s 1 and 3 if Health item 27 other tr			. Place of Dispo	sition (Nan	ne of				20c. Location		own, State						
ē			Burial 2 Cremation 3 Removal from State  Other (Specify)	cemetery, crer <b>EADOWR I</b>				5.17	.2005	ELKRID	GE. M	D						
Baltimore,	perrit. Page Dependent of Important: if any injury or once.		21. Signatur (1) uneral Service Licensee  K. GREGURY FINK HOLL	)_   <del>2</del>	Name an	d Addres	s of Facility	ĎΜE,		IE, MD	2106	1						
	Medical Examiner  Medical Exam	Ical Examiner	Ical Examiner	Ical Examiner	Ical	cal	cal	Ical	shock or heart failure. Dist only one cause on each line.  Immediate Cause (Final disease or o's dition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consulting in death) Last  C. Due to (or as a consulting in death) Last	equence of):	51 A	C	INF ARD	=A	RCTI IASCU DIS	LAR	<u> </u>	Interval Batween Onset and Death VIDE
.O. Box 68	The law requires that the death certificat tie has been signed by the attending phy age 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregular to the past 10 live birth 2 □ Fregnant at time of 9 □ Unknown	etal death 3 □	⊒Ectopic pr ⊒ Other (sp						ate of delive	ery Day Year						
Ω_	uires that signed b	by	Part II. Other significant conditions contributing to death but not respect to the significant conditions.	esulting in the u	inderlying ca	ause give	n in Part I.		23e. Did tob	-/		ne cause of death?						
Il Records,		Completed	CHRONIC RENAL	FAIL	LUR	E			24a. Was ar autops perform 1 \( \text{Yes} \) 2	/		psy findings available mpletion of cause of 2 No						
Vital	Physician: this certific ral director,	Be	25. Was case referre medical examiner? Hospital:			Othe		of Oeath	(Check only one	9)								
of	<u>a</u>	n: To	27. Manny I Death 28a. Date of Injury	☐ ER/Outpatier 28b. Time of		8c. Injury Work	PL-TNU	rsing Ho	me 5 Reside 28d. Describe ho	nce 6 🗆 Oti w injury occu		y)						
<u>io</u>	nding ath. r: Att	atio	2 ☐ Accident investigation	Injury	М		res 2 🗆 1	No										
Division	al or Attendir s after death. Il Director: Al od in by the fu	Certification;	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury · A building, etc. (Special Coulding)	home, farm, str	reet, factory	, office			28f. Location (Sti City or Town		ber or Rura	I Route Number,						
	To the Hoapital or Attending within 24 hours after death.  To the Funeral Director; After completely filled in by the fune	Medical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my leading to the basis of examiner: On the basis of examiner and manner stated.	nowledge, death ination and/or in	h occurred vestigation,	at the tim	e, date an inion, dea	d place, th occurr	and due to the ca ed at the time, da	use(s) and m ite and place,	anner as s and due to	tated. the cause(s)						
	To the To the comp	Σ	29b. Signature and title of certifier		290	License	number	Co	29	d. Date signe	ed (Month,	Day, Year)						
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	Sta Registi		31. Date filed (Month, Day, Year) 32. Registrar's Sig	nature	San Contraction of the Contracti	S. D.		(		_								

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Dav Month Year **Physician** AGNES JANE BEADLE MAY 11, 5:10 РМ 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CROFTON CONVALESCENT CENTER CROFTON ANNE ARUNDEL If Under 1 Year Months Days If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** Months Hours Min 1 ☐ M 2 💢 F 95 6/14/1909 Director 578-46-6496 PENNSÝĽVANIA Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 27 le marked other than "naturel", or Items 23a or 28e-1 ehow traumatic event, the Mcdical Examiner must be nutified at M Yes 2 □ No Directo MARYLAND | PRINCE GEORGES BOWIE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2812 BOTANY LANE 20715 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 and 2 should be filed within 72 hours after of Health and Mental Hyglene. 3m 27 le marked other than "naturel", or Itel 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: USA Specify: If Yes, Give Year or Dates: þ 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) UNITED STATES College (1-4or 5+) Elementary/Secondary (0-12) EXECUTIVE SECRETARY FEDERAL GOVERNMENT 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ANDREW SWARTZ ELIZABETH GLUCK 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 ALAN BEADLE/ SON 2812 BOTANY LANE BOWIE, MD 20715 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 10 = 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If eny injury or once. 4 □ Donation 5 □ Other (Specify) HUNTT CREMATORY 5/14/2005 WALDORF, MD 22. Name and Address of Facility ROBERT E. EVANS FUNERAL HOME 21. Signature of Funeral Service I 16000 ANNAPOLIS ROAD BOWIE, MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Recta 2 years **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, beauty to in modiate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence off Examine executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. attending physician certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐No Month Year ò Day 5 Other (specify) 4□Pregnant at time of death P.O. P the signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, prtic Stenosis 1 Yes 2 No 3 Probably 4 Unknown pieted 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Com 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4x Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 1 No this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Hospitel or Attending Injury 1 Natural 5 Pending after death. 2 🗌 No 1 Tyes investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 5/13/05 035848 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jr 1438 Defensetting Gambrill, mo 21054 Howard KS 31. Date filed (Month, Day, Year) State MAY 1 6 2005 Registrar

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	•	For State Registrar		-	Certificate of			g. No. 🤈 🕦 👩	11 1 /	programme programme		
		Decedent's Name (First, Middle, L	ast)				2. Date of Deat		3. Time	of Death ()		
Physicia /Medic		Ellenor Diane B	aan				May 13,	2005	7:11	A M		
Examin		4a. Facility Name (If not institution, g	ive street and number)		4b. City, Town,	or Location of Death		4c. County of	4c. County of Death			
		Prince Georges H	ospital		Chever1	,		Prince Georges				
Funeral Director		275-38-4707 63 Yrs. 3/5/1942 Ohio								e or Foreign		
pug *	or	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location				10d. Inside	City Limits		
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the /	Director	10e. Street and Number	deorges	оррег 1	10f. Zip Code		1	Og. Citizen of Wh	nat Country?			
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urs Fig.	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:					l V	Vhite			
72 hours "natural", adical Exp	Completed	15. Decedent's (Specify only highest of	Education grade completed)		Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	i during most of work	ina	16b. Kind of Busi Prince (	•			
withir then	ш	Elementary/Secondary (0-12)	College (1-4or 5- 5+	+)		,,,	t	Public S	•			
filed Hygir other		17. Father's Name (First, Middle, La			eacher	18. Mother's Nam						
id be ental ked c	o Be	William A. Hus	twick			Thelma I	Lewis					
shou nd M mar	-	19a. Informant's Name/Relationship		19b.	Mailing Address (Stree			City or Town, S	y or Town, State, Zip Code)			
alth a 27 is		Marc-Eric Christ	opher Baan/	Son 123	337 Chester	ton Drive	Upper M	arlboro,	MD 207	74		
permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: if I fem 27 is marked other then "natur any injury or other traumatic evant, the Medical ODGs.		20a. Method of Disposition	Dameur from State	20b. Place of cemetery	Disposition (Name of crematory or other pla	ical		20c. Location - C	ity or Town, State			
Page nent ant: fi ury o	1 8	1 ☐ Burial 2 ☑ Cremation 3  1 ☐ Donation 5 ☐ Other (Special Control C	cify)	Huntt	Crematory			aldorf,				
pparti poort ny inj		21. Signature of Fuperal Service Licenses 22. Name and Address of Facility Robert E. Evans Funeral Home										
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		shock, or heart failure. List on	ily one cause on each lin	е.				est,	Approxin Interval 8 Onset ar	Between		
Physician		Immediate Cause (Final disease or condition resulting in death)	a. Coko	NARY	ARtery	DISEAS	E		540	ears		
/Medical Examiner		1	Due to (or as a	a consequence o	Malletie	Tune	Z		30'u	en 25		
San F	Examiner	Immediate Cause (Final disease or condition resulting in death)  a. COKONARY ARTERY DISEASE  5 years  Due to (or as a consequence of):  Diabets Mellifis Type I  Due to (or as a consequence of):  Due to (or as a consequence of):										
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The law requires that the death certificate is the has been signed by the attending physicage 2 should be detached for use as the topical control of the tension of the ten	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 ☐ Live birth	2 Fetal death	3 □Ectopic pregnand	; У		23d. Date Mont	,	Year		
e dea the at		1 Yes 2 No	4☐ Pregnant at 9☐ Unknown	time of death	5 Other (specify)				52)			
that the de ned by the a		Part II. Other significant conditions	s contributing to death bu	ut not resulting in	the underlying cause of	ven in Part I.	23e. Did tol	pacco use contrib	oute to the cause of	of death?		
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w require	etec	END STAGEKIE				ON	24a. Was a	24h W	are autonov findia	as available		
has ge 2	Completed	DIVID - COLOR 140	200 yourse	0- ) //	per pro-		autops	ned? 🖊 de	ere autopsy finding or to completion of ath?	cause of		
	e Co	OF Man ages referred to modical				00 Plans of Pass	1 Yes		☐Yes 2☐No			
	o Be	25. Was case referred to medical examiner?  1   Yes   2   Two   Hospital: 1   Tempatient   2   ER/Outpatient   3   DOA   Other: 4   Nursing Home   5   Residence   6   Other (Specify)										
aician: Th s certificate lirector, pag	-	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred										
g Physician: er the certific eral director.			28a. Date of Injur		M 1 Ves 2 No							
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			For 1_ State	State of Maryl	and / Depa		lealth and I	Mental Hygi	_	5 16950	
1. Decedent's Name (First, Middle, Last)							Douin	2. Date of Death	- 197 - 194°	3. Time of Death	
	Physici /Medio		GERTRUDE	A	CARY			Month	Day 200	5 11:10 AM	
	Examir	ner	4a. Facility Name (If not institution, give		New Year		r Location of Death	1	4c. County of De		
			HARBOR HOSPITI			BALTI				I/A	
	Funeral		Social Security Number     6. Se	x 7. Age (In:	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, Day,		lirthplace (State or Foreign Country)	
	Director		219-18-7452	79	)			∐May 27,	1925 N	Maryland	
	pug *		Usual Residence of Decedent  10a. State 10b. County	100	City, Town or Lo	ocation				10d. Inside City Limits	
	aryla sho	-	Tob. Godiny	100	Ony, Town or Ed	Joanon				1 ☐ Yes 2 ☐ No	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "netural", or Items 23e or 28e-f show amy injury or other treumatic event, Ite Medical Eracinal must be notified at once.	Funeral Director	Maryland Anne A	runde1	Pasadena	10f. Zip Code		10	g. Citizen of What		
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	deat	ner	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13.		lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No-	14. Race - Ar	merican Indian,	
9	after or ite	Ē	1 Never Married 2 Married	1 ∐ Yes 2 🛂 No				Hican, etc.)	Black, W	nite, etc.	
8	urs and	by	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1□ Yes 2☑ No	Specity:		Specify:	hite	
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2	othe ent,	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam	ne (First, Middle, Ma			
<u>a</u>	ic e	To E	John	Alfred	Cordes		Gertrud	le A	Alverta	Grahe	
Maryland 21215-0036	short nd N ma	-	19a. Informant's Name/Relationship (T)	ype, Print)		ng Address (Street	and Number or Ru	ral Route Number,			
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ō,	Hez Hez tem othe		20a. Method of Disposition	20	b. Place of Dispo	sition (Name of matory or other place	TO A TOTAL CONTRACTOR	, Marylar Date 20	c. Location - City	or Town, State	
Baltimore,	age ant of t: if		1 ☑ Burial 2 ☐ Cremation 3 ☐ I  1 ☐ Donation 5 ☐ Other (Specify,	Removal from State			Pk. 5/14	/05	lan Davin	. M 1 1	
≢	artme orter injur		21. Signature of Funeral Service Licens		2:	2. Name and Addre	ss of Facility			ie. Maryland	
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			23a. Part. Enter the disease, or comp	lications that squard the						nd 21122 Approximate	
			shock, or heart failure. List only of	ne cause on each line.	eath. Do not en	ter the mode of dyli	ig, such as cardiac	or respiratory arres	it,	Interval Between Onset and Death	
1	nysician		Immediate Cause (Final disease or condition resulting in death)							3 days	
4	/Medical Examiner		resulting in death)	Due to (or as a cor						and and	
	Examiner		Sequentially list conditions.	b	MONIF	1				one week	
V	p #	ner	Sequentially list conditions, if any, leading to immediate raise. For fundarying Cause (Disease or injury that initiated events.	Due to (or as a cor	sequence of):						
	nd nd transit	Examiner	Cause (Disease or injury that initiated events	c							
oʻ	be exec	Ě	resulting in death) Last	Due to (or as a cor	sequence of):						
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68	The law requires that the death certifica Ite has been signed by the atlending ph page 2 should be detached for use as th	Jed	IS ESMALE.								
Вох	h cel endir use	Ş	Physician/Med	230. Was decedent pregnant	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ I		Ectopic pregnancy	,		23d. Date of c	,
œ.	deat e att	Cis	in the past 12 months? 1 □ Yes 2 ☑ No	4☐Pregnant at time		Other (specify)			Month	Day Year	
P.O.	t the by th ache	hys	9 🗆 Unknown	9□ Unknown							
<u></u>	s tha	by P	Part II. Other significant conditions co	ntributing to death but not	resulting in the u	nderlying cause giv	en in Part I.	23e. Did toba	cco use contribute	to the cause of death?	
ğ	v requires that the death certilica been signed by the attending ph should be detached for use as th	d b	T USME D	Α				1 ☐ Yes	2 □ No 3 🗹	Probably 4 □Unknown	
00	w requir been sl should	Completed	RENAL IN	CHERICIE	Y 2016			24a. Was an	24b. Were	autopsy findings available	
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	or A after Direct in by	ıţi.	4  Homicide determined	building, etc. (Sp	ecify)	eet, factory, billion		City or Town,		Total Floore Homber,	
	pital purs eral filled	ŭ	29a. Certifier 1 Y Certifying Phy	sician: To the best of my	knowledge deet	b convered at the time	ma data and place	and due to the cou	00/0) and manage	a a state of	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical Certification:	(Check only 2 Medical Exam	iner: On the basis of exar and manner stated.	nination and/or in	vestigation, in my o	pinion, death occur	red at the time, date	e and place, and d	ue to the cause(s)	
	omple omple	Me	29b. Signature and itte of certifier			29c. Licens	e number		d. Date signed (Mo		
	->-0		1 / Vahalli	chi Mil	).	PI	8437	1	1AY 119	2005	
	, 1		30. Name and address of person who c	ompleted cause of dooth	(Item 23a) (Tues	- ' '					
	11		· · · · · · · · · · · · · · · · · · ·				120 81	BAITIM	ORF. MI	0,21225	
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Amend Trent 10e per in 8843 5-16-05 Vt. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Ma	-	partment of H e <i>rtificate of</i>			giene Reg. No.2	10000		
			Decedent's Name (First, Middle, Las	t)				2. Date of De	eath	3. Time of Death		
	Physici /Medio		Franc	ces Mari	e Crowe			Month	7, 2005	11:00 A <sup>M</sup>		
	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Deat		4c. County of De			
			2825 Lodge Farm	n Road Ap	t. 305	Edger			Balti	more		
	Funeral		5. Social Security Number 6. Se	DM OFF	e (In yrs. last birthda Yrs.	Months Days	If Under 24 Hrs Hours Min.	(Month, Da	rth ay, Year) 9. E	Sirthplace (State or Foreign Country)		
	Director		012-22-6822 "Usual Residence of Decedent	<sup>™</sup> <sup>2</sup> №  78	3 115.			April	16,1927 Ma	ssachusetts		
	land ow		10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits		
	the Marylan 28a-f show	tor	Maryland Ba	altimore			Edger	nere		1 ☐ Yes 2 🔀 No		
	or 28s	lrec	10e. Street and Number		305	10f. Zip Code			10g. Citizen of What	Country?		
	th wil	alD	2825 Lodge E	Farm Road	Apt. 205		21219		United Sta	tes		
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland to Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28a-f show or other treumatic event, the Modical Examinat rusal be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 XDivorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:		3. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	lispanic Origin? (S an, Mexican, Puerl Specity:	pecify Yes or No to Rican, etc.)	14. Race - Ar Black, Wi Specify:	merican Indian, hite, etc. White		
21215-0036	2 hou	ted	15. Decedent's Ed	ucation	16a. De	cedent's Usual Occup	ation		16b. Kind of Busines			
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21	filed wit Hygiene other the	Con	12 Years		.	Sarmange			Hotel Ki	tchen		
nd	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last)						, Maiden Surname)			
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Maryland	12 sh h and 7 Is n treun	1	19a. Informant's Name/Relationship (7 Mr. Edward Crowe			uling Address ( <i>Street</i> 7 Souththo			er, City or Town, State River - Mar	<i>, Zip Code)</i> :yland 21220		
	1 and 1 Health em 27		20a. Method of Disposition	(5011)	20b. Place of Dis	position (Name of		Date	20c. Location - City	-		
Baltimore,	Pages nent of H ant; If Ite		1 ☐ Burial 2 ☑ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specify		i	rematory or other place  Service	1	12/2005		Maryland		
量	교투원급		21. Signature of Funeral Service Licen:		HITTEOL	22 Name and Addre	ss of Facility					
B	Perm Imp any		Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222									
	T-47EM		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused				Approximate				
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	= £71	1 CUSAL	- EUE				Interval Between Onset and Death		
	Examiner			Due to (or as	a consequence of):	Saler	TRE PU	LMUNA	ANY DIS	15 YRS.		
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):	, , , , , , , , , , , , , , , , , , , ,	, , _ ( )		0)-			
V	ficate be executed g physician and is the burial-transit	Examiner	triat initiated events	c								
0,	e exe ian a urial-1	EX	resulting in death) Last	Due to (or as	a consequence of):							
68760,	sate b	edical		d								
		/Me	IF FEMALE:	23c. If yes, outcome	of pregnancy				204 0-1	1-15		
Вох	The law requires that the death certifit tie has been signed by the attending I age 2 should be detached for use as	Physician/M	in the past 12 months?		2 Fetal death	B Ectopic pregnancy	′		23d. Date of o	Day Year		
o.	that the do	lysl	1 Tes 2 No 9 Unknown	9☐ Unknown								
Α,	res that igned b be deta	by PI	Part II. Other significant conditions co	ontributing to death b	ut not resulting in the	underlying cause giv	en in Part I.	23e. Did t	obacco use contribute	to the cause of death?		
rds	v require been sig should b	ed b						100	Yes 2□No 3□	Probably 4 Unknown		
000	aw requ 1s been 2 shouk	Completed						24a. Was		autopsy findings available		
Ä	The lav	E O						auto perfo	ormed? death'			
/ita	yslcien: Th is certificate director, pag	Be (	25. Was case referred to medical examiner?					ath (Check only o				
of Vital Records,	Physicien: rthis certificatal director,	ပို	1 ☐ Yes 2 No		ent 2 ER/Outpat	ient 3 DOA Oth	er: 4 Nursing H		dence 6 Other (Sp	pecify)		
n C	ding P. h. After funera	ion:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry Year) 28b. Time Injur	/ Wor		28d. Describe	how injury occurred			
isi	l or Attending   after death. Director: After in by the funer	icat	2 Accident investigation 3 Suicide 6 Could not be	290 Place of Ini	ury - At home, farm,		Yes 2 □ No	28f Location /	Street and Number or	Pural Pouto Number		
Division	lor A after Direct	Certification:	4 Homicide determined	building, et	c. (Specify)	street, factory, office		City or To	wn, State)	nurar noute rumber,		
	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the funer	edical C	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exam	iner: On the basis of	f examination and/or	ath occurred at the tir investigation, in my o	ne, date and place pinion, death occu	, and due to the pried at the time,	cause(s) and manner date and place, and d	as stated. ue to the cause(s)		
	o the	Mec	29b. Signature and title of certifier	and manner sta	104.	29c. Licens	e number		29d. Date signed (Mo	nth, Day, Year)		
	- s → ō		OXNIL ()	108811	1	06	01864	18	5/9/1			
	/		(30. Name and address of person who of		eath (Item 23a) (Typ	e, Print)			ha	TRO WO		
	9		LOUIS D. DE	SEN M	-282	25 LOD	01864 68 FA	Rou K	9 2	1219		
	Sta		31. Date filed (Month, Day, Year) MAY 1 6 20	32 Aegistr	ar's Signature	hails a						
	Registr	ar	MM1 4 0 26	JUJ KURLING	U SU M	TO STATE OF THE PARTY OF THE PA						

		ŀ	1 ⊷ For State Registrar		Maryland /	•	artmen rtificat			ınd M		Reg.	200	5	16361
	Physici /Medic		1. Decedent's Name (First, Middle, Las Judith A. Compt							_	2. Date of I Month May 1	- 1	Day Y 2005	/ear	3. Time of Death 9:35P M
	Examin		4a. Facility Name (If not institution, give		oer)		4b. City,	Town, or	Location o	f Death			4c. County of	Death	
			17332 Fletchall		. Age (In yrs. last b	inth days	Poo:	Lesv	ille If Under:	24 Hrs	8. Date of E		Montgo		lace (State or Foreign
	Funeral Director		5. Social Security Number 6. S 218-58-8763	ex □M 2 <b>X</b> F	. Age (iii yrs. iasi t 62	Yrs.	Months	Days	Hours	Min.	(Month, I	23 ·	1943 N	Cour	itry) Land
	D		Usual Residence of Decedent												
	arylan show	Ļ	10a. State 10b. County		10c. City, To									1	0d. Inside City Limits 1 ☐ Yes 2 X No
	18a-f	ecto	Maryland Montgome	ry	Gait	hers	burg 10f. Zip	0-4-				10-	Citizen of Wh	at Cour	
	with t	ij	10e. Street and Number	i				0878							•
	ms 23	Funeral Director	12225 Bradbury Dr	12. Was Deced	ent Ever in U.S.	13.	Was Deced	ent of Hi	spanic Orig	gin? (Spe	cify Yes or I		ited St	Americ	an Indian,
9	or Ite	F	1 Never Married 2 Married	Armed Ford 1 ☐ Yes 2 If Yes, Give	. No	1	r Yes, spec 1 ☐ Yes		n, Mexican Specify:	, Puerto	Rican, etc.)			White,	etc.
21215-0036	4 within 72 hours after death with the Maryland jiene. Ir than "naturel", or Items 23e or 28e-f show the Mcdical Examinar must be incitified at	d by	3 Widowed 4 Divorced	Year or Dat	es:								Specify:	Whi	
15-(	n 72 ł "nati	Completed	15. Decedent's Ed (Specify only highest gra	ducation de completed)	16	(Give	dent's Usua kind of wo DO NOT us	rk done d	lurina mosi	of worki	ng	16b	. Kind of Busi	iness/In	dustry
12	within lene. than "	ошо	Elementary/Secondary (0-12)	College (1-4	tor 5+)	Flor		, , , , , , , , , , , , , , , , , , , ,	,			F	loral 1	Desi	.gn
br	e filed il Hygie other vent,	BeC	17. Father's Name (First, Middle, Last)		· · · · · · · · · · · · · · · · · · ·				18. Mothe	r's Name	(First, Midd	le, Maio	den Sumame)	)	
ylar	2 should be f and Mental I Is marked of raumatic eve	ToE	Fred E. Andrews	M. 1-1-0					Bart	ara	Frazi	er			
Maryland	2 sho		19a. Informant's Name/Relationship (				•						ly or Town, Si		i
di	is 1 and 2 should be filed of Health and Mental Hyg item 27 Is marked othe other traumatic event,	1	Kathleen Y. Wino 20a. Method of Disposition	vich/Dau	gnter 20b. Place							_	Lie, Ma		and 20837
nor	ages nt of l t; if it		1 XBurial 2 ☐ Cremation 3 ☐		tate Mono	cacy	natory or o	ther place		lay 2 2005	.6,				
Baltimore,	permit. Pages 1 Department of H Importent; If its eny injury or ot once.	- 1	' 4 ☐ Donation 5 ☐ Other (Specify 21. Signature 1 ☐ n al Service Licer		Ceme	tery	2. Name an	d Addres	s of Facilit	yRobe	ert A.	Pun	nphrey	Fun	, Maryland eral Home/
ñ	Depar Impo	0 6	1 SailE	Den	. моово	3 R	lockvi lockvi	lle,	Inc	, 300 71an	) West 1 208	Mor 50 <b>−</b> 2	ntgomen 2805	су А	eral Home/ venue
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that ca one cause on ea	used the death. Do										Approximate Interval Between
	Pnysician	0	Immediate Cause (Final disease or condition	Lun	g Cancer										Onset and Death
	/Medical Examiner		resulting in death)		r as a consequenc	e of):									
		i i	Sequentially list conditions,	D	acco Use	e offe								-	Williams.
1	uted 1 ansit	Examine	Sequentially list conditions, it may, leading to initial ediate cause. Enter Underlying Cause (Disease or injury that initiated events												
o,	be executed sician and burial-transit		resulting in death) Last	Due to (o	r as a consequenc	e of):									
8760	ate be shysicia the bu	dlcal		d											
9	The law requires that the death certificate be executed the has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Med	IF FEMALE:	O2a If year auto	ama of programmy								T		
Вох	eath certific attending pl	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 🗆 Live bir	ome of pregnancy th 2 Fetal dea nt at time of death		Ectopic pr						23d. Date Monti		ory Day Year
o.	at the de by the a tached	ysic	1 ☐ Yes 2 🔯 No 9 ☐ Unknown	9□ Unknov		_	3 0 11 10 1 (0)	,							
Δ.	es that igned b be deta	by Pł	Part II. Other significant conditions of	ontributing to dea	ath but not resulting	in the u	nderlying c	ause give	n in Part I.		23e. Dio	tobaco	co use contrib	ute to th	ne cause of death?
ıdş	w require been sig should b										10	Yes	2 □ No 3	☐ Prob	ably 4 Unknown
ecc	e law re has be e 2 sho	Completed									24a. Wa	ODSV	pri	or to co	psy findings available moletion of cause of
E R		Con									1 Yes	formed 2X	? de No 1	ath? Yes	2 No
Vital Records,	Physicien: T this certificat al director, pa	Be	25. Was case referred to medical examiner?	Hospital:				Othe			(Check only		. V		Daughter's
of		7: To	1 ☐ Yes 2 🛣 No  27. Manner of Death	28a. Date of		. Time o		Bc. Injury Work					6 (A) Other		Residence
ion	ath. r: Afte e fune	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investigatio	(Month	, Day Year)	Injury	М		<br Yes 2⊡i	No					
Division	Hospitel or Attending 14 hours after death. Funerel Director: Afte tely filled in by the fune	Certification	3 ☐ Suicide 6 ☐ Could not be determined	286. Place 0	of Injury - At home, g, etc. (Specify)	farm, st	reet, factor	, office			28f. Location City or 7			or Rura	l Route Number,
	urs aft rel Di														
	Hospitel 24 hours Funerel stely filled	edical			pest of my knowled sis of examination a ar stated.										
	To the Hospitel or Al within 24 hours after of To the Funerel Direct completely filled in by	Me	29b. Signature and title of certifier	1			290	. License	number			29d.	Date signed (	Month.	Day, Year)
	> - 0		1	7				D622	234			Mar	y 12,	2005	
	,0		30. Name and address of person who												***
	In		Manish Agrawal, N	20 20	07 Medica gistrar's Signature				vе, #	300,	Rockv	i11	e, Mar	ylar	d 20850
	Sta Regist		31. Date filed (Month, Day Year) 6	2005	gistrar's Signature	A	perte	,							

			1 - State of Maryla		artment rtificate			and M	ental Hy	ygiene Reg. Ne	2000	5_16362
П	Physicia	an	1. Decedent's Name (First, Middle, Last)						2. Date of D Month	Da		
	/Medic Examin	al	John Frederick Cove  4a. Facility Name (If not institution, give street and number)		4b. City.	Town, or	Location o	of Death	May 1		005 County of D	8:30 P. <sup>M</sup>
	Examini	eı	Shady Grove Adventist Hospita	ı1		kvi1	_				Montgo	
-	Funeral		5. Social Security Number 6. Sex 7. Age (In y	rs. last birthday)	If Under Months	1 Year Days	If Under:	Min	8. Date of B	irth	9.	Birthplace (State or Foreign Country) SSachussetts
L	Director	}	030-16-1171   123-M 2 F   77	Yrs.					Feb. 2	4, 19	28 Ma	ssachussetts
	yland how			City, Town or Lo	ocation							10d. Inside City Limits
	e Mar	ctor	Maryland Montgomery	Rockvill	Le							1 X Yes 2 □ No
	with th	Funeral Director	10e. Street and Number		10f. Zip						izen of What	
	leath ns 23	eral	1114 Fallsmead Way  11. Marital Status 12. Was Decedent Ever in	n U.S. 13.	Was Deced	854 lent of Hi	ispanic Orig	ain? (Spe	cify Yes or N	<u> </u>	ed Sta	tes merican Indian,
9	72 hours after death with the Maryland natural; or Itams 23a or 28a-f ahow Jisal Evantinet must be mottled at		Armed Forces?  1 □ Never Married 2 ▼ Married 1 □ Yes 2 □ No		If Yes, spec 1 ☐ Yes 2	ify Cuba	n, Mexican Specify:	n, Puerto	Rican, etc.)		Black, W	/hite, etc.
903	ural,	d by		11							Specify:	
5	in 72 in 72 in mat	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usua kind of wor DO NOT us	k done c	during most	t of worki	ng	16b. K	ind of Busine	ss/Industry
212	d with giene.	om	Elementary/Secondary (0-12) College (1-4or 5+)	Se	DO NOT us enior (	Nat: Offi	ional cial	Seci	urity	Fee	dera1	Governmemt
Maryland 21215-0036	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last)				18. Mothe	er's Name	(First, Middle	e, Maiden	Sumame)	
<u>Z</u>	hould d Men marke natic	7	James W. Cove  19a. Informant's Name/Relationship (Type, Print)	10h Mail	na Addrosa	(Stroot o	•		e McCa		Tour Cha	a. Zio Codo)
Na	nd 2 s lith an 27 la i		Marion Quinn Cove/Wife									1 20854
Jre,	of Hearlitam		20a Method of Disposition 20	<ul> <li>b. Place of Dispo</li> </ul>	osition (Nam	e of		May 2005		20c. Lo		or Town, State
Baltimore,	Page ment c ant: If ury or		1 🕅 Burial 2 □ Cremation 3 □ Removal from State ( '4 □ Donation 5 □ Other (Specify)	Gate of Cemete	ery		,			Man	ryland	
Balt	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 ia marked othar than "natural", or Itams 23a or 28a-f ahow amportant: othar traumatic avant, Ita Medical Ever in an invality or collists at once.	l la	21. Signature of Funeral Service Licensee M01353	Ro Ro	2. Name and OCKVII OCKVII	Te,	Inc. Mary	300 1and	West 1 20850	Pump Monte -2805	ohrey	Funeral Home/ Avenue,
			23a. Part1. Enter the disease, or complications that caused the dishock, or heart failure. List only one cause on each line.	· i	. 1			cardiac o	r respiratory	arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		resulting in death)	DAZLY	yThe	419						Seconds
	Examiner		Due to (or as a cons	sequence or:	tus							į
	ם ≃	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	sequence of):								
V	ecute and I-trans	Examiner	Cause (Disease or injury that initiated events c	seguence of):								
8760,	death certificate be executed e attending physician and ed for use as the buriat-transit			yoduonido oi).								
9	= 0,0	Completed by Physician/Medical	U									
Вох	that the death certif ed by the attending detached for use a	ian/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pre 1 □ Live birth 2 □ F	etal death 3	⊒Ectopic pre						23d. Date of Month	delivery Day Year
0.	the de	ysic	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of 9 ☐ Unknown 9 ☐ Unknown	of death 5 L	Other (spe	ecify)						,
s, P.	s that the ned by th e detache	y Ph	Part II. Other significant conditions contributing to death but not	resulting in the u	ınderlying ca	ause give	en in Part I.		23e. Did	tobacco u	use contribute	e to the cause of death?
ords	w requires that s been signed t should be det	ed b	Digbeter Mellitus						1 🗆	Yes 2	□No 3□	Probably 4 Unknown
of Vital Record	The law rute has be bage 2 shi	nple				_			24a. Wa auto	DDSV	prior	autopsy findings available to completion of cause of
al B									peri 1 ☐ Yes	formed? 2 No	death 1 🗆 Y	
VIII.	Physician: r this certific ral director.	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 No  Hospital: 1 ☐ Inpatient 2	2  ER/Outpatier	-1 2 00	Othe			<i>(Check only</i> me 5 ☐ Res		2 CO+ (0	
l of	g Phy er this eral d	n: To	27. Manner of Death 28a. Date of Injury	Mr. Constitution of the Co		8c. Injury Work	4 🗀 140		28d. Describe			респу)
sior	Attanding I r death. actor: After by the funer	catlo	2 Accident investigation	, injury	М		Yes 2 1	No				
Division	I or Attano after death Diractor: I in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - A building, etc. (Spe	it home, farm, sti ecify)	reet, factory,	, office		2		(Street an own, State		Rural Route Number,
	To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my 2 Medical Examiner: On the basis of exam and manner stated.	knowledge, deat ination and/or in	th occurred anyestigation,	at the tim in my op	ne, date and pinion, deat	d place, a	and due to the	cause(s)	and manner d place, and d	as stated. due to the cause(s)
	To tha within 2 To tha comple	Me	29b. Signature and title of certifier				number	$\sim$		29d. Dat	te signed (Mo	onth, Day, Year)
						138	841	1		5/1	3/0:	>
	10+1		30. Name and address of person who completed cause of death (I David Klein, M.D. 9901 Medic	al Cent	,	ve,	Rock	ville	e, Mar	y1and	20850	)
	Sta Registr		31. Date filed (Month, Day, Year)  MAY 1 6 2005	gnature	Sports	2						

		-	For State Registrar	State of M	arylanc		artment			and M		ieņe	)5	1638	53
	Physicia		1. Decedent's Name (First, Middle, Las Miriam B. Crawfor	-			7.5	-			2. Date of Dea Month May 6,	2005	Year	3. Time of E	Death AM
	/Medic Examin		4a. Facility Name (If not institution, giv. Wilson Health Car	street and number,	)		4b. City, Gaith		Location o	of Death		4c. Count Mon	y of Death	)	
	Funeral Director		3//-03-9328	ex 7. Ag ☐ M 2 🖾 F	ge (In yrs. Ia 91	st birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birth (Month, Day Nov • 20	, 1913	9. Birth Cou Wash	place (State or intry) ington,	Foreign DC
	Maryland -f ahow	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland Montgome	rv	10c. City,	Town or Lo	cation					, <u>, , , , , , , , , , , , , , , , , , </u>		10d. Inside City 1 ☐ Yes	
	or 28e	Funeral Director	10e. Street and Number				10f. Zip				1	0g. Citizen of	What Cou	intry?	
	ath w	ra	6010 Roosevelt St					0817		: 0.40	7 17 11	Unite			
980	d within 72 hours after death with the Maryland giene. rr than "natural", or Itams 23a or 28e-f ahow the Madical Examiner must be notified at	þ	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	12. Was Decedent Armed Forces 1 □ Yes 2\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	?  No		Was Deced If Yes, spec 1 ☐ Yes 2			gin? (Spe i, Puerto I	cify Yes or No- Rican, etc.)		ck, White	ican Indian, , etc. nite	
21215-0036	within 72 ho ene. than "natur ne Medical	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	de completed) College (1-4or	5+)	(Give life.	dent's Usua kind of wor DO NOT us	rk done d e retired,	ition furing most	t of workin	ng	16b. Kind of E		ndustry	
	filed w Hygier other th		17. Father's Name (First, Middle, Last,	2		H	omema	ker	18 Mothe	r's Namo	(First, Middle,	Own			
Maryland	od tail	~	Robert Ernest Beal					]	Migno			ynes			
Man	s 1 and 2 should f Health and Men itam 27 ia marke other traumatic		19a. Informant's Name/Relationship (				•				Route Number	-			,
Baltimore, I	ges 1 and it of Healt if itam 2 or other		Carol C. Rudolph/ 20a. Method of Disposition 1 □ Burial 2 🖾 Cremation 3 □	Removal from State	20b. Pla	ace of Disponentery, cremon transfer in the contract of the co	sition /Nan	ne of	1.			20c. Location	- City or T	Town, State	
Him	permit, Pages Department of I Important: If its any injury or of	Ī	* 4 ☐ Donation 5 ☐ Other (Specification of Funeral Sevine Light)		Crem	22	2. Name an	d Addres	s of Facilit	y Rob	ert A.	Pumphr	ev Fu	laryland Ineral H	lome.
Ä	permi Depa Impo any id		MAJI		00689		Bet	hesd.	a, Ma	rvla	e, Inc. nd 2081	4-3501	Wisco		
	Pnysician		23a Part / Ener the disease, or com shock of heart failure. List only Immediate Cause (Final disease or condition	plications that cause one cause on each	ine.	. Do not ent	er the mod							Approximate Interval Betw Onset and D	veen
	/Medical Examiner		resulting in death)	Due to ra	s a consequ	ence of):	ai	0	~	12.	w				,
	pe tis	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (ur a	s а солѕ <del>в</del> ци	HATICH OF		0	7						
8760, <	ite be executed iysiclan and ne burial-transit	ical Examiner	cades (Disease of Injuly that initiated events resulting in death) Last	cDue to (or a	s a consequ	ence of):									
.O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcom 1 Live birth 4 Pregnant a	2 🗌 Fetal	death 3	]Ectopic pr ] Other <i>(sp</i>					1	ate of deli		ear
<u>α</u>	quires that i n signed by uld be deta	by	Part II. Other significant conditions of	stind	ale	edi	na				23e. Did to	_/		the cause of de	
Records,		Completed	Anemia, co	Bust	car	nce	rhs E	id			24a. Was a autop perfor 1 \( \subsection Yes	sv ,	Were autorior to condeath?	topsy findings a ompletion of ca	vailable use of
Vital	ician: 1 certifica ector, p	Bec	25. Was case referred to medical examiner?						26. Place		(Check only or				
of V	Physic this coral dire	ို	1 ☐ Yes 2 ☑ No		tient 2 🗆 E						me 5 Resid			ify)	
ono	ling f	tlon:	27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of In (Month, D	lay Year)	28b. Time o Injury	M M	8c. Injury Work	rat ⟨? Yes 2□		28d. Describe h	ow injury occu	irrea		
Division	P S S C	Certification:	3 Suicide 6 Could not be determined	289. Frace of It	njury - At hor atc. (Specify	me, farm, sti	reet, factory	, office			28f. Location (S City or Tow		ber or Ru	ral Route Numb	ner,
	To the Hospital or within 24 hours afte To the Funeral Dirt completely filled in t	edical		nysician: To the bes miner: On the basis and manners	of examinati						ed at the time, o	date and place	, and due	to the cause(s)	
•	To the I within 2: To the I complet	2	29b. Signature and title of certifier  No. Raheul	Birse	ubs	- Cu	290	License U	number	15	2	29d. Date sign	ed (Month	, Day, Year) 2005	_
	15		30. Name and address of person who	completed cause of	death (Item	23a) (T)pe,	Print)	201 A	PU	SSE. EKS.	LAVE	NUS	208	77	
	Sta Registr	ite	31. Date filed (Month, Day, Year) MAY 1 6	2005 32. Rais	trar's Signat	ture	parte	,							

		1 - For State Registrar	State of Marylar		nent of Health and cate of Death		ne) 05	6364
		Decedent's Name (First, Middle, Last,	)			2. Date of Death	.110.	3. Time of Death
Physic	ian	Ronald E		Sr.		Month	Day Year	
/Med						5 -	12- 05	12:05 PM
Exami	ner	4a. Facility Name (If not institution, give		/ 4b.	City, Town, or Location of Dea	ith	4c. County of Death	
		tranklin Square	Hospital (e)	nter	Kosedale		Baltimor	e
Funeral Director		186-32-7164	7. Age (In yrs	Mo	Inder 1 Year If Under 24 Hr onths Days Hours Mir		1939 PA	place (State or Foreigntry)
DG		Usual Residence of Decedent  10a, State 10b, County	10c C	ity, Town or Locatio				Od. Inside City Limits
In y failed within 72 hours after death with the Maryland 2 should be filed within 72 hours after death with the Maryland and Mental Hygiens.  Is marked other than "natural", or Itams 23a or 28e-f show aumatic event, the Madical Examiner must be notilized.	_					_		1 ☐ Yes 2% No
8 M	Director	MD Balti	more		Middle Rive	<u> </u>		1 103 22 110
or 2	ire	10e. Street and Number		10	f. Zip Code	10g	, Citizen of What Cou	ntry?
h wi	a C	12433 Eastern	Ave.		21220	U	SA	
daat ms	Funeral	11. Marital Status	12. Was Decedent Ever in U	J.S. 13. Was I	Decedent of Hispanic Origin? ( , specify Cuban, Mexican, Pue	Specify Yes or No-	14. Race - Americ	
tter tra	Ē	1 Never Married 2 Married	Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give			по нісап, віс.)	Black, White,	
nd 2 should be filed within 72 hours at the and Mental Hygiene.  27 Is marked other than "natural", or traumatic event, the Marical Exemple.	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	101	es 2. Specify:		SpecifyWhit	ce
hor ru	eg	15. Decedent's Edu	cation	16a. Decedent's	Usual Occupation	16	b. Kind of Business/In	dustry
n 72	et	(Specify only highest grad	e completed)	(Give kind	of work done during most of w OT use retired)	orking		•
withi sha.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Heavy	EquipmentOpe	erator	Construct	cion
filed Hygie other	ပိ	11th 17. Father's Name (First, Middle, Last)		neavy		ame (First, Middle, Ma	idon Sumamo)	
ba fi	Be		_			an Keroch		
Men Men arke	2	Norman Ditzle	Г		VIVIO	an keroch	mer	
and sum		19a. Informant's Name/Relationship (T)	rpe, Print)	19b. Mailing Ad	dress (Street and Number or F	Rural Route Number, C	City or Town, State, Zip	Code)
		Evelyn Ditzler	/wife	1243	3 Eastern Av	7e. Balti	more MD	
- i a =		20a, Method of Disposition	20b.	Place of Disposition cemetery, cremator	(Name of		c. Location - City or To	
Pagas nent of int: If it		1°☐ Burial 2 ☐ Cremation 3 ☐ F  1 ☐ Donation 5 ☐ Other (Specify)	Removal from State		Rematory	16/05 B	altimore	MD
parmit. Page Department of Important: If any injury or once.				_		- L		
armi epa npo ny ir		21. Signature of Funeral Service Licens	ee / /	22. Nai	ne and Address of Facility	onnellyFu	neralHom	eofEssex
0.0 ≥ € 0		1. Jerry	Canel	vy	300 MACE AV	e. Baltim	ore MD 2	1221
		23a. Part1. Enter the disease, or come shock, or heart failure. List only or	cations that caused the dea	ath To not enter the	mode of dying, such as cardi	ac or respiratory arres	t.	Approximate Interval Between
Pnysician		Immediate Cause (Final	/					Onset and Death
/Medical		disease or condition resulting in death)	d	ncer				
Examiner			Due to ( s a conse	querice oi).				
	<u>.</u>	Sequentially list conditions,	b. — Due to (or as a conse	guanas of):				
<u>ت</u> و	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause juisease or injury	Due to (or as a conse	equence or):			1	
eath certificate be executed attending physician and for use as the burial-transit	Examiner	that initiated events	C					
an a		resulting in death) Last	Due to (or as a conse	quence of):				
te be ey ysician e buria	cai		d					
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death cartifica e attending ph	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregr				23d. Date of delive	erv
atter for u	lar	in the past 12 months?	1 Live birth 2 ☐ Fet 4 Pregnant at time of		pic pregnancy er (s <i>pecify</i> )		Month	Day Year
000	Sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	3000	i (apocity)		Î	
Tha taw requires that the de tite has baen signed by the sage 2 should be detached	Ph			In the	to the beat	220 Did toho	cco use contribute to the	no acuse of death?
gner gner be d	by	Part II, Other significant conditions co	nthouting to death but not re	isuiting in the under	/ing cause given in Part i.			
an s	ed					1 X Yes	2 □ No 3 □ Prob	ably 4 Unknow
ha taw requires t e has baen signe	Completed					24a. Was an	24b. Were auto	psy findings availabl
na ta	E					autopsy performe	d? death?	mpletion of cause of
cate						1□ Yes 25	No 1 ☐ Yes	2 No
Physicien: Tha lav rthis certificate has ral director, page 2	Be	25. Was case referred to medical examiner?	In a mittalla			eath (Check only one)		
hysi his c	10	1 195 2010		1			e 6 □Other (Specif	y)
ding Ph h. After th funeral	Ë	27. Manner of Death 1 S Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how	injury occurred	
Attending ir death. actor: After by the funer	atic	2 Accident investigation		N.				
# 9 9 5 E	을	3 Suicide 6 Could not be determined	28e. Place of Injury - At I	home, farm, street, f	actory, office		et and Number or Rura	al Route Number,
A - BB C	-	4 Homicide	building, etc. (Spec	ary)		City or Town,	State)	
or Attence after death Diractor:	ē		sician: To the best of my kn	nowledge death occ	urred at the time, date and place	se and due to the cau	se(s) and manner as s	tated
pitel or A	il Certification;	29a Cartifier 1 Certifying Phy		ation and/or investig	ation, in my opinion, death oc	curred at the time, date	and place, and due to	the cause(s)
Hospitel or A 24 hours after Funerel Dirac		29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	ner: On the basis of examin	iation and or invosti				
the Hospitel or A hin 24 hours after the Funerel Dirac mpletely filled in by		(Check only 2 Medical Exami	ner: On the basis of examin and manner stated.		20c License number	204	Date signed (Month	Day Yearl
To the Hospitel or A within 24 hours after To the Funerel Dirac completely filled in by	Medical Cer	(Check only 2 Medical Exami	ner: On the basis of examin and manner stated.		29c. License number	290	. Date signed (Month,	Day, Year)
i Si fi fi		(Check only 2 Medical Exami	ner: On the basis of examin and manner stated.		29c. License number D6176	29d	. Date signed (Month, 5   12   200	Day, Year)
To the Hospitel or A within 24 hours after To the Funeral Dirac completely filled in by		(Check only 2 Medical Exami	ner: On the basis of examin and manner stated.		29c. License number D6176	290	Date signed (Month, 5   12   200	Day, Year)
To the Hospitel or A within 24 hours after to the Funerel Dirac completely filled in by		(Check only 2 Medical Exami	ner: On the basis of examin and manner stated.		29c. License number D6176 Square Dr	1 29d	Date signed (Month, 5   12   200	Day, Year) <b>8</b>
To the Hospite within 24 hours To the Funerel completely filled		(Check only 2 Medical Exami	ner: On the basis of examin and manner stated.		D6176	1 29d	Date signed (Month, 5   12   200 more, Md	Day, Year)  5 21237

		4	1 - State Registrar	State of Ma	•	artment of Healt rtificate of Dea		ntal Hygie	2000	16265
			Decedent's Name (First, Middle,	Last)			2	. Date of Death	-	3. Time of Death
	Physici /Medio		EDNA RUT	H EVERET	Г		M	AAY 11,	2005 Year	10:00pM
	Examir		4a. Facility Name (If not institution,	give street and number)		4b. City, Town, or Local			4c. County of Death	1
			129 S. DURHA				IMORE		N/A	
	Funeral Director		212-36-1068	7. Ag	e (In yrs. last birthday) 66 Yrs.	If Under 1 Year If Un Months Days Hot	nder 24 Hrs. 8 urs Min.	Date of Birth (Month, Day, Y JULY 14	9. Birth Cot 1, 1938 W.	place (State or Foreign intry) VIRGINIA
	and and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	death with the Maryland ms 23e or 28a-f show It iust be routified at	ģ	MD. N/A		BALTI	MORE				1 X Yes 2 □ No
	r 28a	Funeral Director	10e. Street and Number			10f. Zip Code		10g	. Citizen of What Co	untry?
	th with	aiΩ	129 S. DURHAM	STREET		21231			U.S.A.	
		ner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of Hispani f Yes, specify Cuban, Me	c Origin? (Specif	ly Yes or No-	14. Race - Amer Black, White	
21215-0036		þ	XXNever Married 2☐ Marrie 3☐ Widowed 4☐ Divorced		No		ecity:	3411, 010.7	Specific	HITE
5-0	72 hours "natural", vicel Ex-	eted	15. Decedent's (Specify only highest	Education grade completed)	16a. Dece	dent's Usual Occupation	most of working	16	b. Kind of Business/I	ndustry
21		Completed	Elementary/Secondary (0-12)	College (1-4or 5	) )	kind of work done during DO NOT use retired)			DOMEGRA (	7
2	e filed val Hygie othar ti	S	17. Father's Name (First, Middle, La	act)	HOU	SEKEEPER	Aother's Name (	First, Middle, Ma	DOMESTIC	
Maryland	s 1 and 2 should be filed withing Health and Mental Hygiene. Itam 27 la marked othar than othar treumetic evant, Item	) Be	EARL EVERETT	131/			24		FRAZIER	
IZ.	should be nd Mental marked mertic ev	ဥ	19a. Informant's Name/Relationship	p (Type, Print)	19b. Maili	ng Address (Street and No				ip Code)
M	nd 2 suith ar		SANDRA LOWERY			S. DURHAM				
ē,	s 1 au if Hea itam otha		20a. Method of Disposition			sition (Name of matory or other place)	Dat		c. Location - City or 1	
- 6	Page nert o int: If iry or		1 ☐ Burial 2 ☐ Cremation 3  `4 ☐ Donation 5 ☐ Other (Spe		1	CREMATOR	y 5/14/	/05 BA	ALTIMORE	MARYLAND
Baltimore,	permit. Pages 1 and Department of Health Importent: If itam 27 any injury or othar tr once.		21. Signature of Funeral Service Li	censee	1	Name and Address of F	acility ILER IN	NC. FUN	NERAL HON	ИE
			23a. Part1. Enter the disease, or c	omplications that caused	the death. Do not ent	901 EASTE				Approximate
	Pnysician /Medical		shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	a	410/0/	ecuhit	1 111	11/15	2515	Interval Between Onset and Death
ı	Examiner		Sequentially list conditions	b	cropequence of):	0 S2 N	35 6	/		
7	bed isit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):					
V	be executed iician and burial-transit	хап	that initiated events resulting in death) Last	c. Due to (or as	a consequence of):					
68760	cate be execu physician and the burial-tra	alE								
687		edical		d						
.0. Box	death cert e attendin ed for use	Completed by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deli Month	very Day Year
	requires that the een signed by th nould be detache	/ Ph	Part II. Other significant condition	s ontributing to death b	ut not resulting in the u	nderlying cause given in F	Part I.	23e. Did tobac	cco use contribute to	the cause of death?
gp	uires I sign Id be	d b	Flment	77				1 🗌 Yes	2 □ No 3 □ Pys	bably 4 Donknown
ecords,	law req as beer 2 shou	iete	Etillin	to the	WA.			24a. Was an	24b Were aut	opsy findings available
Se.	9 - 9	щc	1 41/1114	10-11111				autopsy performe	d? prior to c death?	ompletion of cause of
tal	ician: Th certificate rector, pag	a	25. Was case referred to medical			26 F	Place of Death (0	1 Yes 2	1 LI Yes	2 □ No
of Vital	Physician: this certific ral director,	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatie	ent 2 ER/Outpatier	0.0			ce 6 ☐ Other (Spec	ify)
0			27. Man of Death	28a. Date of Inju (Month, Da	ry 28b. Time o			d. Describe how		
100	Attending r death. ector: After by the fune	atic	2 Accident investiga	tion	, , , , , , , , , , , , , , , , , , , ,	M 1 ☐ Yes	2 □No			
Division	after de after de l'Direct	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determine		ury - At home, farm, sti c. (Specily)	eet, factory, office	281	f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,
	Hospite 4 hours Funara tely fille	edicai C	(Check only 2 Medical E.	xaminer: On the basis o	f examination and/or in	n occurred at the time, dat vestigation, in my opinion,				
	To the Hospital or Attendi within 24 hours after death. To tha Funaral Director: A completely filled in by the fu	Med	one) 29b. Signature and title of certifier	and manner sta	ated.	29c. License num	ber	29d	. Date signed (Month	, Day, Year)
)			Munh	1 amil	MI	7/130	1/2	6	1/12/6	35
	2		JUAN WIT	no completed cause of c	leath (Item 23a) (Type,	Print WOOD	R	By	to Ma	212/8
	Sta Registi		31. Date filed (Month, Day, Year)		ar's Signature	South)			. 0)	
			111/71 4							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 太 FOUNTAIN HOWARD MAIN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Northwest Hospital Center Randallstown Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Dec. 23, 1 Birthplace (State or Foreign Country)
 New York 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 74 1**X** M 2 ☐ F Yrs. 075-24-5730 Director 1930 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits itam 27 ia marked othar than "natural", or Itams 23e or 28e-f show other traumatic avant. the Medical Examiner must be notified at 1 Yes 2 No Md. Baltimore Reisterstown Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 105 Fitz Ct., Apt. 103 21136 U.S.A. Be Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) U.S. Army Military Man 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) George Fountain Agnes LaRocque 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marlene Fountain - Wife 105 Fitz Ct., Apt. 103, Reisterstown, Md. 21136 Department of Health Important: If itam 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State ö Maryland Veterans Cem. May 17, 2005 Owings Mills, Md. any injury o \* 4 □ Donation 5 Other (Specify) 21. Signature of Fuperal Service Licensee 22. Name and Address of Facility
Eckhardt Funeral Chapel, P.A. 11605 Reisterstown Rd. Owings Mills, Md. 21117 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** LANDH disease or condition resulting in death) FAILURE MINICESTIVE /Medical Due to (or as a consequence of): Examiner SCHEMIC CARDIOMORPATH Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): the attending physician and resulting in death) Last Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months? Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown ò signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown page 2 should Be Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒️ No certificate has 1 ☐ Yes 2 🙀 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Malinpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 ☐ Yes 2 📉 No this 28c. Injury at Work? Manner of Death 28b. Time of 28d. Describe how injury occurred After or Attanding 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a Hospitel fortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 D Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 13/1 Mella mo 2015. D 41410 MAY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 356,1206R P WEHTR MO HISPITH CENTER RANDAUS TOWN MO MORTH WEST 31. Date filed (Month, Day, Year) 32. Registrar's Signature MAY 1 6 2005 Registrar

			For State Registrar	State of Ma	aryland / I		rtment o			Mental H	ygiene	2005	9	0 6 -7
			Decedent's Name (First, Middle	, Last)						2. Date of D	eath	Year	3. Time	of Death
۲	Physicia /Medic			Albert	Gera	ard,	Sr.			Month 05	Day	200	5 6	14 PM
	Examin		4a. Facility Name (If not institution,		IN DITA		4b. City, Tov				4c.	County of Deat		
				ARITAN F	(In yrs. last bi		If Under 1 Y		Under 24 H		lirth	N/	A hplace (Stat	e or Foreign
	Funeral Director		235-20-8885	1₩ M 2□F	34	Yrs.			ours Mi		7,19	Co	t Vir	_
	D		Usual Residence of Decedent											
	laryla show	2	10a. State 10b. County		10c. City, Tov	n of Loc	ation						10d. Inside	es 2 XNo
	the M 28a-f	Funeral Director	Maryland Bal	timore			10f. Zip Co		ndalk		10a. Citiz	zen of What Co		
	3a or	Ī	6739 Fifth Av	enue					212	22	_	ited St		
	death	nera	11. Marital Status	12. Was Decedent I	Ever in U.S.	13. W	/as Deceden	of Hispar	nic Origin?	(Specify Yes or herto Rican, etc.)	10-	14. Race - Ame Black, White		
စ္တ	or Its	y Fu	1 Never Married 2 Marri	ed 1∑Yes 2□1 If Yes, Give	10		☐ Yes 2【		pecify:	ono moan, oto.,		Specify:		
ë	within 72 hours after death with the Maryland ene. than "natural", or Itams 23a or 28a-f show the Modical Exemities in ust be multified at	ed by	3 Widowed 4 Divorced	Year or Dates:	WWII	Decede	ent's Usual C	ecupation				nd of Business/	White	<del></del>
7	nin 72 n "na	Completed	(Specify only highes Elementary/Secondary (0-12)	t grade completed)  College (1-4or 5		(Give k	ind of work of O NOT use i	lone durin	g most of w	vorking	I OD. Tell	14 01 04011003	industry	
212	d with giene gretha	Com	8 Years	College (1-40) S	+)	P	lant E	ngin	eer		Ма	nufactu	ring	
2	be filed tal Hygi d other event, II	Be	17. Father's Name (First, Middle, I	Last)				18.		lame (First, Midd	-			
<u> </u>	should be find Mental B marked of umatic eve	<u>ک</u>	Sebestiano Ge		1	. 6.4 - 117				ia There			Tin Ondal	
Maryland 21215-0036	d 2 sh th and 7 Is m traum		19a. Informant's Name/Relationsh Mr. Albert D.							Rural Route Num ve Germ	-			20874
	s 1 and I Health tem 27 other tr		20a. Method of Disposition		20b. Place	of Dispos	ition (Name atory or othe	of		Date	20c. Lo	cation - City or	Town, State	
Ë	Pages nent of 8 int: If its iry or o		1X3 Burial 2 □ Cremation  14 □ Donation 5 □ Other (Sp						Cem.	5/13/20	05 D	undalk,	Mary	land
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-f show any Injury or other traumatic event, It's Modical Examiter must be multiled at once.		21. Signature of Funeral Service	icensee		22.	Name and A	ddress of	Facility	Home of	Dund	alk In	С	
_	89 2 2 8 9		125/4			7	922 W:	ise A	ve.	Dundalk,	Mary	land !	21222	
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caused only one cause on each li	the death. Do ne.	not ente					arrest,		Approxin Interval E Onset ar	Between
	Priysician / /Medical		Immediate Cause (Final disease or condition resulting in death)	a	PIRAT		I F	NEL	MON	SIA				
9	Examiner				a consequence		4	ED	EM	A				
		Jer	Sequentially list conditions, it any, leading to immediate	D	a consequence	•			- 1 17					
V	cuted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	с.										
8760,	cate be executed physician and the burial-transit	I Ex	resulting in death) Last	Due to (or as	a consequence	of):								
387	physical phy	edical		d		-								
Box 6	es that the death certific igned by the attending p be detached for use as	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome							2	23d. Date of del	ivery	
m	death e atte	Physiclan/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown			Ectopic pregi Other (speci					Month	Day	Year
P. O.	at the 1 by th etache	Phys	9 Unknown							22- Di				4
	Attanding Physicien: The law requires that the death certificate be executed redath. r death. actor: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	by	Part II. Other significant condition  CHRONIC C	BSTRUCTIV			NARY	_				se contribute to ⊒No 3 □ Pr	obably 4	
Records,	a law require has been sig e 2 should b	Completed	CORONARY	ARTERY	DISC					24a. W	is an topsy rformed?	24b. Were au prior to death?	itopsy finding completion o	gs available f cause of
	icien: The lav certificate has ector, page 2		END STAG	E RENAL	0.7	SE	ASE			1 Tyes	2 1 No	1 ☐ Yes	2 No	
⋚	scerti	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	ent 2 EB/C	utnatient	3 □ DOA	Othor		Death <i>(Check onl</i> ight) GHome 5 Re		S ∏Other (Spe	cifv)	
٥	g Phy erthis		27. Manner of Death	28a. Date of Inju		Time of Injury		Injury at Work?		28d. Describ			,	
Sior	andin sath. or: Aff he fur	atlo	1 ☐Natural 5 ☐ Pendin 2 ☐ Accident investig	gation			М		2 🗆 No					
Division of Vital	e Hospital or Attanding Physicien: The I 24 hours alter death. e Funeral Diractor: After this certificate ha etely filled in by the funeral director, page.	Certification:	3 Suicide 6 Could r 4 Homicide determ		ury - At home, i c. <i>(Specify)</i>	arm, stre	et, factory, o	ffice			(Street and own, State,	d Number or Ri )	ıral Route N	umber,
	spital			g Physician: To the best										
	To the Hospital or within 24 hours affer To the Funeral Dir. completely filled in I	ledical	one)	Examiner: On the basis o and manner st		nd/or inv				ccurred at the tim				
	To the within 2. To the complet	Σ	29b. Signature and title of certifier	0			1	icense nu				e signed (Mont		)
•	,		Nchan	·	'P'	_			000			-9-0		
	821		30. Name and address of person NEENA C	HAWLA, S	601 L	DCH	RAV	EN	Вош	EVARD	BAL	TIMO	RE, MI	5-2123
	Sta Registr		31. Date filed (Month, Day, Year)	32. Regist	ar's Signature	k ,	herte	j						
	•		11171				*							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 20c per in 8843 5-16-05 vt.

State of Manyland (100) Printed and Mental Hygiene

			For State Registrar	State of Mar		oarfment of F e <i>rtificate of</i>		-	ene 9. No. () () 5	15358
	Physici /Medic		Decedent's Name (First, Middle, La  ALLEN	ast) DAV	ID	GOLD	/ARG	2. Date of Death Month MAY	Day Year <b>10 2005</b>	3. Time of Death
	Examir		4a. Facility Name (If not institution, gir FUTURE CARE CHE			4b. City, Town, o	REISTER		4c. County of Death	
	Funeral Director		190-07-5450 X		In yrs. last birthda 86 Yrs.	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, AUG. 24,	Year) 9. Birth Cou 1918 PA	place (State or Foreign intry)
	s within 72 hours after death with the Maryland jiena. I than "natural", or Items 23a or 28a-1 show tre Markisal Examinat must be notified at	al Director	Usual Residence of Decedent           10a. State         10b. County           MD         BALTI           10e. Street and Number         1840           REISTERST	MORE	Oc. City, Town or	BALTIMORE  10f. Zip Code  21208		10	g. Citizen of What Cou USA	10d. Inside City Limits 1 ☐ Yes 2 ☐ No XX
9036	nours after death	d by Funeral	11. Marital Status  1  Never Married 2 Married  XXVIdowed 4 Divorced	12. Was Decedent Ev Armed Forces? XXYes 2 □ No If Yes, Give Year or Dates: W		3. Was Decedent of H If Yes, specify Cuba 1 Yes 2XXNo	lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify: W	
121215-0036	J within jiena. r than "	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12) 12	ade completed)  College (1-4or 5+)	(Gir	cedent's Usual Occup ve kind of work done DO NOT use retired	during most of work	ring	6b. Kind of Business/In	
Maryland	should be filled Mental H markad ott markad ott umatic evan	To Be	17. Father's Name (First, Middle, Las UNKNOWN	GOLDV			JEANETT		SILVERBE	
Baltimore, Mar	permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, once.		DR. ARTHUR COLDV  20a. Method of Disposition  XX Burial 2 Cremation 3 I  4 Donation 5 Other (Speci	ARG/SON  Removal from State fy)	120 20b. Place of Dis cemetery, co BNAI IS	89 LONG LA position (Name of rematory or other place RAEL CONG. 22. Name and Addre SOLLEVINS	AKE DR: OF STATE OF S	WINGS MIL Date  3/2005  S., INC.	Oc. Location - City or To XON  OXEN HILL,	2.1117 own, State
68760,	Physician and // Medical be executed by physician and street price is the purial-transit	edical Examiner	23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a c	consequence of):	Note the mode of dyir	STERSTOWN g, such as cardiac	RD PIKE or respiratory arres	ESVILLE, ME	Approximate interval Between Onset and Death
P.O. Box 68	aath cartif attending for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 ZNo 9 Unknown	23c. If yes, outcome of 1 □ Live birth 2   4 □ Pregnant at tin 9 □ Unknown	Fetal death 3	☐Ectopic pregnancy	,		23d. Date of delive	ery Day Year
	w requiras that the de been signed by the should be detachad	by	Part II. Other significant conditions	contributing to death but	not resulting in the	underlying cause giv	en in Part I.		cco use contribute to the	
Vital Records,	The la ate has page 2	Completed						24a. Was an autopsy performe 1 \( \text{Yes} \) 2 \( \text{L}	prior to co death?	opsy findings available impletion of cause of
Division of Vit	To the Hospital or Attending Physicien: To the Funate Site death. To the Funatel Director: After this certific completely filled in by the funeral director.	Certification; To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Matural 5 Pending investigation  3 Suicide 6 Could not be	19	28b. Time Injury	of 28c. Injur Wor M 1	er: 4 Nursing Ho	28d. Describe how	ce 6 Other (Specify injury occurred	
Divi	Hospital or Al 24 hours efter of Funaral Dirac tely filled in by		4 Homicide determined	building, etc. (	(Specify)			City or Town,		
	To the Hospital within 24 hours e To the Funeral C completely filled	Medical	(Check only one)  2 Medical Exa  29b. Signature and title of certifier	nysician: To the best of r miner: On the basis of ex and manner state	camination and/or	investigation, in my o	pinion, death occur	red at the time, date	e and place, and due to be and place, and due to d. Date signed (Month,	the cause(s)
,	F3F8		> Paymend M	ulle ins	the (language)	D 4768			5/10/05	
10			30. Name and address of person who Rhy Mond Miller 25 31. Deterfiled (Month, Day, Year)	Main Street.	Soute 200	Reistes jour	MD 2	.1136		
	Sta Registr		MAY 1 6 20	33 Registrar's	S Signature	and the				

# 1 - State Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** ,2005 2200PM MAY OMINIC /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** AGNESHEALTHLARE BALTIMOR If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 M 2□ F Director 213-07-4/24 West JAN 30, 1913 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 27 is marked other than "natural", or Items 23a or 28e-f shov treumatic event, the Modical Examiner must be notified at CATONSVILLE 1 ☐ Yes 2 No Directo MARYLAND 10e. Sheet and Number 10f. Zip Code 10g. Citizen of What Country? 2115 death Funera 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ♥ No Specify: White Completed by 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d 2 should be filed within 7. In and Mental Hyglene. 7 is marked other than "n. Elementary/Secondary (0-12) College (1-4or 5+) BETHLEHEM STEEL STEELWORKER 9+4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be RANK 1ARIA JULIAN 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2/228 2115 Old Frederick KOAD Department of Health Importent: If item 27 MARJORIE JEANNE GRIFFIN 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 Donation 5 NOther (Specify) ENTONG WEST AKLAWN CENETERY MAY 19,2005 21. Signature of Juneral Service Licens 22. Name and Address of acility. INO JR. eny i CONKLING 721224 Fart1. Enter the disease, or complishock, or heart failure. List only or Approximate Interval Between Onset and Death hs that caused the death. Do not enter the mode of dying, such as cardiac coespiratory arrest, use on each line. Immediate Cause (Final 05/7/05-05/14/05 PNEUMONIA Priysician biration disease or condition resulting in death) /Medical Due to or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examine use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 4 Pregnant at time of death 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? res 2 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Na Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 TYes 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Mannet of Death 28d. Describe how injury occurred Natural 5 Pending death. 2 🗀 No 1 Tyes investigation 2 Accident within 24 hours after deati 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🗹 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier P18 623. Quihar May, 14, 2005 CHAUHAN, 900 CATON AVENUE, BALTIMORE, MD21229. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHANDANA Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 2005 Christine Csop Herman Mau 11:03 AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore 4810 Torpoint Road Baltimore. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Aug. 15 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year Days 1 ☐ M 2 🖫 F Yrs. Aug. 189-03-3272 1915 Pennsylvania Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Importent: if Item 27 is marked other than "natural", or iteme 23e or 28e-f show any injury or other treumatic event, the Madical Examinat Injurited at once. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Hanover Township PA Luzerne 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18706 116 Lyndwood Avenue u.s.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Garment Industry Seamstress 11th Grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Wasyl Csop Pauline Semchiew 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4810 Torpoint Road, Baltimore, MD 21236 Mr. Daniel Herman (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 🕅 Removal from State St. Mary's Cemetery 5/12/2005 Hanover Twp., PA ' 4 □ Donation 5 Other (Specify) 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of al Service Licens 9705 Belair Rd., Baltimore, MD 21236 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) dlon **Physician** /Medical Due to (or as a consequence of): Examiner stati Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ettending physicien and for use as the burial-transit The law requires that the death certificate be executed 51.14 Mal Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 pronths?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 □Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown 1 ☐ Yes No Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 2 No Yes 1 Yes To the Hospitei or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify Residence 2 Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 2 1 Tyes 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification; After 1 Natural 2 ☐ Accident 5 Pending death. М 1 ☐ Yes 2 ☐ No investigation within 24 hours after death To the Funerel Director: / completely filled in by the f 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \( \text{Homicide} \) 29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. C215 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State of Maryland		ment of H		d Menta	Hygiei	000	7.5	10071
	Physici	an	Decedent's Name (First, Middle, Last	)		: /		2. Date Mor	of Death	Day	rear_	3. Time of Death
	/Media	al	4a. Fecility Name (If not institution, give	etreet and number)	A	b. City, Town, or	RIS	m/A	4 1	4c. County of	205	605 /1 M
	Examin	ier	STELLA MAG	LIS HOSPICE		13 L		YORE		4c. County of	1)	12
	Funeral		Social Security Number 6. Se	7. Age (In yrs. I	ast birthday)	f Under 1 Year	If Under 24		of Birth	25)	9. Birthpla	ace (State or Foreign
	Director		×16-00-6070	□M 2 <b>X</b> F 7	Yrs.	lonths Days	Hours	Min. SEF	TS/	932 1	ENA	54LVANIA
	and		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Locat	ion	-				10	d. fnside City Limits
	f sho	ō	MARILLIA	IA		0	HAR	2 F. /	7.	/	10	1 Yes 2 No
	r 28a	Director	10e. Street and Number	, , ,		10f. Zip Code	THOP	E	10g.	Citizen of Wh	nat Count	ry?
	15 with	aiD	1505 W, 1	105HER ST	REET		210	217		US	A	
	ams ser or	Funerai	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?		s Decedent of Hi es, specify Cuba	ispanic Origin	? (Specify Yes	or No-	14. Race		
36	or it	by Fu	1 Never Married 2 Married	1 ⊟Yes 2, ŠNo If Yes, Give		Yes 2 No	Specify:		,	Specify:	n .	
5-0036	should be filed within 72 hours after death with the Maryland Id Mental Hygiene. marked other than "natural", or Itams 236 or 28a-f show matic event, Ita Medical Examiner must be notified at	ed b	3 ☐ Widowed 4 ⚠ Divorced  15. Decedent's Edu	Year or Dates:	16a Deceden	t's Usual Occupa	ation		16h	. Kind of Busi	OZ/	ACK
15	nin 72	Completed	(Specify only highest grad	de completed)	(Give kin	d of work done of NOT use retired	during most of	working	100	. Kind of Busi	11655/11101	ustry
212	giene giene er tha	E O	Clementary/Secondary (0-12)	4 VRS	ADMIN	ISTRATI	VE AS	5515TA	NT D.	EPT, O	FSC	CIAL SERVICE
p	ould be filed Mental Hygid Mental Hygid arked other	Be (	17. Father's Name (First, Middle, Last)	(UNKNOWN)			18. Mother's	Name (First, I	Aiddle, Maid	ten Sumame,	)	
aryland	should but and Ment	2						LIE				
Mar	" = m =		19a. Informant's Name/Relationship (T)			Address (Street a						
e,	permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other tra		KICHARD HTARRIS  20a. Method of Disposition		lace of Disposition	NCHE	STER	Date /	YARTI	Location - C	eG/f	WV, 25401
no.	Pages nent of int: If it		1 ☐ Burial 2 Cremation 3 ☐ F	Removal from State	emetery, cremate	ory or other plac	· 1			000		
altimore,	nit. Partme ortan injuri	1	<ul> <li>4 □ Donation 5 □ Other (Specify)</li> <li>21. Signature of Funeral Service License</li> </ul>		22. N	ame and Addres	ss of Facility					E, MD. RAL HOME
ñ	permit. Departr Importa any inji		(2) intrinh	N. 4 Sillian	30		H JA.	TON A	IF. F	BATO	HA	21217
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	fications that caused the death	. Do not enter ti			diac or respira	tory arrest,	<i>,,,,,,</i>		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	- LAIN	a Co	UCOR						Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequ		V CON						
	Examiner	_	Sequentially list conditions,	b								
	led Isit	Examiner	cause. Enter Underlying Cause (Disease or injury	Due to for as a consequ	ienau otj:							
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8760	death certificate be executed e attending physician and nd for use as the burial-transit	dicai E		d								
9	tificat ig phy as thi	ledic		u.								
Box	leath certifie attending p	an/N	230. Was ubcodoni prognant	23c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal		topic pregnancy				23d. Date	of deliver	y
	e deal	sicie	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of de	eath 5 Ot	her (specify)				Month	n [	Day Year
J.	ires that the de signed by the a I be detached i	by Physician/Me	9 Unknown		Main and the second and				District	1		
JS,	The law requires that the te has been signed by th vage 2 should be detache	l by	Part II. Other significant conditions co	ntributing to death but not resu	liting in the unde	riying cause give	en in Part I.	230	1 des			cause of death?
Ö	w require been sig should b	etec						- 1				
Records,	has ge 2	Completed						_ 24a	Was an autopsy performed:	24b. We prid	re autops or to com ath?	sy findings available pletion of cause of
		e Co	25. Was case referred to medical				00 Flore of	1 🗆	Yes 2		Yes 2	P□ No
>	Physicien: The la this certificate has ral director, page 2	0 0	examiner?	Hospital: 1 ☐ Inpatient 2 ☐ E	ER/Outpatient :	3 DOA Othe		Death <i>Check</i> ng Home 5□		6 Other	/s	INICO -
	<u>-</u> = 2	T iu	27. Manner of Death		28b. Time of Injury	28c. Injury Work	at			jury occurred		
000	endir sath. or: Af he fu	atic	1 Accident 5 Pending investigation	(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			Yes 2 □ No					
DIVISION	ol or Attending Pt s after death. I Director: After th d in by the funeral	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At hor building, etc. (Specify,	me, farm, street,	factory, office		28f. Loca City	tion (Street or Town, St	and Number ate)	or Rural	Route Number,
	pitel o		, , , , , , , , , , , , , , , , , , ,	<u> </u>			-	1				
	To the Hospitel or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	edicai	29a. Certifier 1 Pertifying Phy (Check only one) 2 Medical Exami	sician: To the best of my know iner: On the basis of examinati and manner stated.	wiedge, death oc ion and/or invest	curred at the tim igation, in my op	ie, date and pl pinion, death o	lace, and due to occurred at the	o the cause time, date a	(s) and mann and place, and	er as sta d due to t	ted. he cause(s)
	Nithin Fo the	Me	29b. Signature and title of certifier	(		29c. License	number		29d. [	Date signed (	Month, D	ey, Year)
,			1/10- 1/1	e Desan.	no	n	078	30	n	May 1	4.	2005
<b>A</b>	7		30. Name and address of person who ca	ompleted cause of death (Item	23a) (Type, Prin	it)	301	57.	8001	Por		- 0,3
1			MARVIN	FELDN	MY K	18	B	ct. 1	nd.	2/2	UZ_	
	Sta Registr	_	31. Date filed (Month, Day, Year)	32. Registrar Signati	ure A	And .	,					

1 - For Stete Registrar Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last)
Debra Harris—Anderson 3. Time of Death 2. Date of Death Month **Physician** May /Medical ution, give street and number) County of Death Name (If not institution. 4b. City, Town, or Location of Death 4c. **Examiner** AM 8. Date of Birth (Month, Day, Year) LO 08 53 (In yrs. last birthday) 9/Birthplace (State or Foreign **Funeral** Months Days Hours 1 □ M 212 F 51 Yrs. Ιď Director MD 218-58-9245 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10b. County 10a, State 10d. Inside City Limits 28a-f show other traumatic avent, the Medical Examiner must be notified at 1 XYes 2 No Directo Baltimore MD10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Items 23e 3400 Woodland Apt 3-B 21215 Ave U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ò 1 ☐ Yes 2 X No Specify: ģ Specify: Black 3 Widowed 4 Divorced Year or Dates: "natural" Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7. It and Mental Hygiene. 7 Is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) Hospital Dietary Assitant 12th grade 2yrs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Melva P Brooks William Harris Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an ent: If item 27 is Otis Anderson-Husband 3400 Woodland Ave, Baltimore, Md 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State ō permit. Page Department Important: If any injury or ` 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 5/13/05 Baltimore, Md 21. Signatur f Funeral Service Licensee 22. Name and Address of Facility
March F/H West 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 4300 Wabash Ave, Baltimore, Md 21215 Approximate Interval Between Onset and Death Immediate Cause (Final div ase or condition resulting in death) Physician /Medical consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) 9 🗌 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 **1**00 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an director, page 2 Metaboliz 2000 Heidosis 1 ☐ Yes Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Impatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA in by the funeral 28c. Injury at Work? 28d. Describe how injury occurred Certification: After or Attending 1 Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No after death Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral E 1 dertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Hedicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) State Registrar

			State of Maryland / Dep		•	ne 2005 1505
	Physici	an	Decedent's Name (First, Middle, Last)  Vincinia Man II  Vincinia Man	1		ay Year
	/Medic Examin	al	Virginia Mae Han  4a. Facility Name (If not institution, give street and number)  5509 Winton Avenue	4b. City, Town, or Location of Death Balto		9 2005   11:30 a. <sup>M</sup> Ic. County of Death N/A
	Funeral Director		5. Social Security Number 216-34-5644 6. Sex 1 M 2 F 7. Age (In yrs. last birthday 1 M 2 F 68 Yrs.	) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Yea 8 29 19	9. Birthplace (State or Foreign Country) Va
	e Maryland la-f show lifted at	ctor	10a. State         10b. County         10c. City, Town or U           Md         N/A         Balto	ocation		10d. Inside City Limits 1 ሺ Yes 2 ☐ No
	with th	i Dire	10e. Street and Number 5509 Winton Avenue	10f. Zip Code 21207		Citizen of What Country?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or Items 23e or 28e-f show any injury or other treumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Spit Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☒No Specify:		14. Race - American Indian, Black, White, etc.  Specify: Black
Maryland 21215-0036	f within 72 ho pene. r then "natur the Medical I	Completed by	Elementary/Secondary (U-12)   College (1-40r5+)	edent's Usual Occupation e kind of work done during most of work DO NOT use retired) a Professional	ing 16b.	Kind of Business/Industry
/land	ould be filed Mental Hyg arked other	To Be C	17. Father's Name (First, Middle, Last) Unk	18. Mother's Name Mary J	e (First, Middle, Maide ane	эn Sumame)
	and 2 sho saith and I n 27 is ma		Vanessa Hankins - Daughter 6		al Route Number, City :Ville <u>Md</u>	
Baltimore,	Pages 1 ment of He ent: If iter ury or oth			position (Name of ematory or other place) norial Park 5-14-	2005 Rar	Location - City or Town, State
Balt	permit. Departimport any inj		21 Signature of Funeral Service Licensee	22. Name and Address of Facility 4300 Wabash A	March F/H venue Bal	
	Physician /Medical		23a. Hart. Enter the disease, or b implications that caused the death. Do not enshook, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. ———————————————————————————————————	nter the mode of dying, such as cardiac PEDIAL INFORMATION		Approximate Interval Between Onset and Death
8760,	ificate be executed  a physician and  ts the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  C. Due to (or as a consequence of):	CARDIOVASCULAR DI	SCASE	25 yr
.O. Box 68	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as the	Physician/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
٥.	quires that in signed b uld be deta	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
Vital Records,	: The taw requir cate has been si ; page 2 should i	Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1  Yes 2 No
Division of Vita	To the Hospitel or Attending Physician: Th within 24 hours after death.  To the Funerel Director: After this certificate completely filled in by the funeral director, pag	ation; To Be	25. Was case referred to medical examiner?  1  Yes 2 No  1  Hospital: 1  Inpatient 2  ER/Outpatie  27. Manper of Death 1  Natural 5  Pending 2  Accident investigation  28a. Date of Injury (Month, Day Year)  28b. Time Injury	ont 3 DOA Other: 4 Nursing Ho	me 5 Residence 28d. Describe how inj	
Divis	Hospitel or Attend 24 hours after death Funerel Director: tely filled in by the	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
	he Hospite in 24 hours he Funerel pletely filled	edicai	29a. Certifier (Check only one)  1. Certifying Physician: To the best of my knowledge, deal call Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, nvestigation, in my opinion, death occurr	and due to the cause( red at the time, date ar	s) and manner as stated. nd place, and due to the cause(s)
į	To the within 2 To the complet	Σ	29b. Signature and title of certifier  Barry A Hold MD	29c. License number		Pate signed (Month, Day, Year)
	3		30. Name and address of person who completed cause of death (Item 23a) (Type 2 of MILL Rol; Suite 1	105 BACHO: Ma	1 21208	3
	Sta Registi		31. Date filed (Month, Day, Year) 32. Restrar's Signature MAY 1 6 2005	Sperte		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item#22, perFH,G843.5/16/05 TI State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death JENKINS 6:30AM **Physician** MURTIMER 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
Ral Curaco Examiner Rausells Town
If Under 1 Year If Under 24 Hrs. Northweg 7. Age (In yrs. last birthday)
7 9 Yrs. 5. Social Security Number Birthplace (State or Foreign
Country) **Funeral** Days 1**M** 2□F 241-32-6666 NORTH CAROLINA **Director** Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits d other than "naturel", or items 23a or 28a-f show event, the Medical Eventrer must be notified at 1 Yes 2 No ALTIMORE Director MARYLAND 10e. Street and Number 10g. Citizen of What Country? USA. EISTERSTOWN 21215 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No ρ 3 Widowed 4 Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry pentary/Secondary (0-12) College (1-4or 5+) THGRADE FINISHER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should be Department of Health and Mental Department of Health and Mental Important: If item 27 is marked o MILLIE HERRY LITTLE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) BALTO, MD. 21215 D. JENKINS (WIFE) 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State injury or BUTUS CEMETERY 5-18-05 ARBUTUS 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Cility BROWN TR. Fundamental Service Licensee

22. Name and Address of Cility BROWN TR. Fundamental Homes

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.

23a. Part 2. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.

25a. Part 2. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. any Immediate Cause (Final disease or condition resulting in death) **Physiclan** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed Due to (or as a consequence of): physician a s the burial-P.O. Box 68760, Physician/Medical as attending p IF FEMALE: esn 23c. If yes, outcome of pregnancy
1□Live birth 2 □Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ pe 3 Probably 4 Unknown 1 🗆 Yes Completed need 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? has page . this certificate 1 ☐ Yes 2 46 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: To 1 ☐ Yes 2 € 100 1 ☐Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specity) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident the To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide hours after Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 To the 29c. Licease number 29d. Date signed (Month, Day, Year) 29b. Signature and title D 44508 13 completed cause of death (Item 23a) (Type, Print) 30. Name and addre als) IMPERIAL 31. Date filed (Month, Day, Year)

MAY 1 State 2005 Registrar

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	Examir	ner	\ / A	CENTER			ORE, M		40.00	Junty of Death	10	
	Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.		Year	9. Birthp	lace (State or	Foreign
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	land ow		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Lo	ocation				1	0d. Inside City	Limits
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	or 28	Direc	10e. Street and Number	) 44		10f. Zip Code			10g. Citize	n of What Coun	try?	
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nor	0 0		Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specifi	Removal from State	emetery, crei	natory or other plac	c <del>a</del> )			-		
Baltimore,	그는만큼		21. Signature of Funeral Service Licen		EKI G. NOF	TOUTE. VA. ME	ss of Facility	30000	TR	FILALER	DAJ HO	ME
ä	Depariment Department		Wietrich,	V. Willia	ms >	5955 K	J. FULT	ON AVE	BI	7270.M	0212	117
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8760,	cate be executed oblysician and the burial-transit		resulting in death) Last	Due to (or as a conseq	uence of):							
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2			MAJID CINA, 22 31. Date filed (Month, Day, Year)	2 S. GREENE  32. Registrar's Signa	ST., B	ALTMORE		20862	-			
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	Physici /Medio Examir	cal	Decedent's Name (First, Middle, Las     Genevieve  4a. Facility Name (If not institution, give	Viola K	(ruszewski	4b. City, T	own, or	Location of		2. Date of Dea Month May	5, 20 4c. County	of Deat	
	Funeral Director		Holly Hill Manor 5. Social Security Number 215-10-9874 6. Se		e (In yrs. last birthday) 91 Yrs.	If Under 1	WSON 1 Year Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day Feb. 2]	Year)	9. Birti Coi	imore Co.  hplace (State or Foreign untry) aryland
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be tiled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "neturel", or Items 23e or 28a-f show eny injury or other traumatic event, Ire Marical Examiner qual be nutflied at once.	To Be Completed by Funeral Director	Usual Residence of Decedent  10a. State  MD  N/A  10e. Street and Number  1101 St. Paul Str  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  15. Decedent's Ed  (Specify only highest gradenty/Secondary (0-12)  17. Father's Name (First, Middle, Last)  Unknown  19a. Informant's Name/Relationship (7 Linda B. Kruszews  20a. Method of Disposition  1 Burial 2 Cremation 3 4 Donation 5 Other (Specify  21. Signature of Funeral Service Licenty	12. Was Decedent Armed Forces?  1 □ Yes 2 00 H 16 Yes, Give Year or Dates:  ucation de completed)  College (1-4or 5)  Unknown  ype, Print)  ki - Daugh	Ever in U.S. 13.  No 16a. Dece (Give life.)  19b. Maili 1101  20b. Place of Disp. camatery, cre Holy Ros.	e 10f. Zip 0 212 Was Decede If Yes, specification of work Do NOT use Seams  St. Position (Nammatory or official 2012)	202 ent of His fy Cubar fy Cubar X No  Occupa k done d e retired) stres aul e of her place	tion uring most  SS  18. Mother Unkr  od Number Stree  ery 5,	of working some set Ur	city Yes or No- lican, etc.)  If Griest, Middle,  Route Numbe  nit 141  ate	Men I  Maiden Surman  Unkno  C, City or Town,  Balti  20c. Location	s CI me)  State, Z  more City or Te,	rican Indian, a, etc.  Ihite  Industry  othing  Tip Code)  2, MD 21202  Town, State  Maryland
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	or Attending Physicien: ufter death. Diractor: After this certifica in by the funeral director. p	Certification: To Be Com	25. Was case referred to medical examiner?  1  Yes	Hospital: 1  Inpatie 28a. Date of Inju (Month, Da  28e. Place of Inj building, et	iry 28b. Time of Injury	of 28	lc. Injury Work 1 🗆 Y	r: 4 Nur	rsing Hom 2 ło	perfor 1 Yes  (Check only or ne 5 Resid. Rescribe has necessary to the nec	med? 2 1 No  ne)  ence 6 Oth  ow injury occur	death? 1 Yes  ner (Spec	2 No
<b>)</b>	To the Hospital or Attent within 24 hours after dealt To the Funerel Director: completely filled in by the	Medical (	(Check only one)  2 Medical Examone)  29b. Signature and title of certifier	iner: On the basis of and manner sta	ey M.O.	vestigation,	License	number	h occurre	d at the time, d	ate and place,	and due	to the cause(s)
	Sta Regista		31. Date filed (Month, Day, Year) MAY 1 6	32. Regent	rar's Signature	Sperks	1						

			For State Registrar	State of M	laryland /		artmen rtificat				-	giene Reg. No.	00	5	16377
	Physici	an	1. Decedent's Name (First, Middle, L	•					***		2. Date of De Month	ath Day	Y	ear	3. Time of Death
	/Medic				aymond	Ke]						IAY	11,2	005	7:32A M
	Examir	ner	4a. Facility Name (If not institution, g Saint Joseph			3 3~	4b. City,	Town, or	Location o	of Death DWS(	171	4c.	County of		more
	Funcial				ge (In yrs. last i		If Under	1 Year	If Under		8. Date of Bir	th			
	Funeral Director		187-03-9927	.53.40.7	82	Yrs.	Months	Days	Hours	Min.	(Month, Da June 1	ı <i>y, Year)</i>			ce (State or Foreign r) Jersey
	pu ,		Usual Residence of Decedent		10-01-7-		1								
	shov	7	10a. State 10b. County		10c. City, To	wn or Lo	ocation							10d	I. Inside City Limits 1 ☐ Yes 2 ☑ No
	tha N 28a-f	Director	Maryland Bal	timore			10f. Zip	Code	D	unda.	Lk	10a Citi:	en of Wha	at Country	
	3a or	Di	96 Delmar Aven	116			101. 2.0	0000	212	22			nited		
	death	Funeral	11. Marital Status	12. Was Decedent		13.	Was Deced	lent of Hi			cify Yes or No Rican, etc.)		4. Race -	American	Indian,
98	or ite		1 Never Married 25 Married		No		1 ☐ Yes		Specify:		rican, etc.)	1	Black, Specify:	White, etc	2.
Ö	72 hours after death with the Maryland naturel', or items 23a or 28a-f show dical Examinar must be motified at	d by	3 Widowed 4 Divorced	Year or Dates:	WWII								13.5	Whit	
15	in 72	Completed	15. Decedent's (Specify only highest g	rade completed)		a. Dece (Give lite.	dent's Usua kind of wor DO NOT us	il Occupa k done d e retired	ation <i>luring</i> mos ')	t of worki	ng	16b. Kir	nd of Busin	ness/Indus	stry
212	d with piena. rr thau	mo	Elementary/Secondary (0-12)  12 Years	College (1-4or	5+)		Mach					S.	teel	Indu	strv
pu	al Hyg	Be C	17. Father's Name (First, Middle, Las	st)						er's Name	(First, Middle,				=== /
yla	Ment Ment arkad aric e	Tof	Raymond Kelly								Е	lmir	a Whi	ltse	У
Maryland 21215-0036	12 shuh and rism		19a. Informant's Name/Relationship								<i>i R</i> ou <i>te Numbe</i> alk, Ma				
	1 and Healtl em 27		Mrs. Betty V.	Kelly (Wi	20b. Place				/e. ]		ate Ma		ation - Cit	11222	
Baltimore,	permit. Pages 1 and 2 should be filad within 72 hours after death with the Marylan Department of Health and Mental Hygiena. Importent: If item 27 Is marked other than "naturel", or items 23a or 28a-f show any injury or other traumatic event, I're Medical Examinational be notified at anone.		1XD Burial 2 Dremation 3	_	сете	tery, crei	matory or o	ther place	· 1						
Ħ	artme orten injury		* 4 ☐ Donation 5 ☐ Other (Spec 21. Signature of Funeral Service Lic	•	HOTT	22	2. Name an	d Addres	s of Facilit	tv	1/2005				r, MD
B	Depa Depa Impo any ir		ot show	Max	ساره عد		)uda-F	luck	Fune:	ŕal H	Home of Indalk,	Dung	dalk, zland	Inc 212	· 22
			23a. Part1. Enter the disease, or conshock, or heart failure. List only	mplications that cause	ed the peath. De									A	pproximate Iterval Between
	Physician		Immediate Cause (Final disease or condition		C ENCE										nset and Death
	/Medical Examiner		resulting in death)	Due to (or as	s a consequenc	e of):									
Ŀ	-xammer	-	Sequentially list conditions,	U	OLIC C		IAC	ARRE	EST						
	ted nsit	nine	n any, leading to inimediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequenc	o 01).								N	
Ć.	exacun and ial-tra	Examiner	that initiated events resulting in death) Last	C. Due to (or as	s a consequenc	e of):									
8760,	cate be exacuted physician and the burial-transit	dicai		d											
9	artitica ing ph e as th	Med	IF FEMALE:									-1			
Box	death certitic e attending pl id for use as t	by Physician/Me	23b. Was decedent pregnant in the past 12 months?		2 Fetal dea		Ectopic pre					2	3d. Date o	f delivery Da	ay Year
0	0 0 0	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐ Pregnant a 9⊡ Unknown	at time of death	5	Other (sp.	ecify)							.,
Q.	The law requires that the date has been signed by the cage 2 should be detached	y Ph	Part II. Other significant conditions	contributing to death	but not resulting	in the u	nderlying ca	ause give	n in Part I.		23e. Did to	obacco us	e contribu	ite to the o	cause of death?
rds,	quires in sign	q pe	ACUTE RENAL FAIL	URE							101	res 2	No 3[	] Probabl	ly 4 □Unknown
of Vital Record	law requir as been s 2 should	Completed	HYPERCALCEMIA								24a. Was		24b. Wer	e autopsy	findings available
Ä	hysicien: The lav his certificate has I director, page 2 a	mo									autop perfo	mad? mad? 22 No	deat	th?	letion of cause of
/ita	iicien: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?						26. Place	of Death	(Check only o			7	1,10
) t	Physicien: r this certific ral director,	2	1 Yes 2 No	Hospital: 1 Inpati				-	4 L 140		ne 5 ☐ Resid			Specity)	
	tending Ph feath. tor: After th the funeral	Certification:	27. Manner of Death  1 Natural 5 Pending	28a. ate of Inju (Month, Da		. Time o	f 28	Bc. Injury Work			8d. Describe I	now injury	occurred		
Division	I or Attendi after death. Director: A In by the fu	ficat	2 Accident investigation 3 Suicide 6 Could not	be 200 Place of In	iury - At home	farm str			/es 2 □ !	-	8f. Location (5	Street and	Number o	or Rural R	oute Number
<u>S</u>	of or A after I Direct d in by	ertii	4 ☐ Homicide determine	building, e	tc. (Specify)	idirii, oti	oot, ractory	, onice			City or Tow	m, State)	744771007	, , , , , , , , , , , , , , , , , , , ,	odio rvariber,
	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the fune		29a. Certifier Certifying F	Physician: To the best	of my knowled	ge, deat	h occurred a	at the tim	e, date an	d place, a	nd due to the	cause(s) a	and manne	er as state	od.
	the Hin 24 the Fi	Medicai	(Check only one) Medical Exa	aminer: On the basis of and manner si	of examination a tated.	ind/or in	vestigation,	in my op	inion, deal	th occurre	d at the time,	date and	olace, and	due to the	e cause(s)
	Tom	2	29b. Signature and title of certifier			>	29c.	License	number				signed (N	-	y, Year)
•	,		- Our	~~~	-ce			32	1263			03	- 11-	-02	
1	1011		30. Name and address of person who												
	Sta	te	FRANCIS KHOO  31. Date filed (Month, Day, Year)	M. D. 76.71 32. <b>Ø</b> gist	rar's Signature	R_D	RIVE	TOL	ISON_	MAR	YLAND	212	214		
	Registr	1	31. Date filed (Month, Day, Year) MAY 1 6	2005	un B.	B	الماء	,							

	1 _ For State	State of Maryla				lental Hy	giene ()	05 16378
	Registrar  1. Decedent's Name (First, Middle, Last)		Cel	tificate of	Death		leg. No.	10.7
Physician	HELEN		KA	RPA		2. Date of Dea Month MAY 11	Day 2005	3. Time of Death 12:45 A M
/Medical Examiner	A Fight Many Mr. of the state of	treet and number)			or Location of Death		4c. County	
E .	HOSPICE OF BALTIM				TOWSON			BALTIMORE
in the Maryland or 28a-1 show carefulled at Director	212-40-0049	7. Age (In y	rs. last birthday) 88 Yrs.	If Under 1 Year Months Days		8. Date of Birtl (Month, Day AUG.18	1916	Birthplace (State or Foreign Country)  VA
/land	Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or Lo	cation				10d. Inside City Limits
Many Many Many Many Many Many Many Many	MD BALT	IMORE	BALT	IMORE				1 ☐ Yes 2 ☑ No
Mith the Mar tor 28a-f sh be notified	10e. Street and Number			10f. Zip Code			10g. Citizen of V	Vhat Country?
death with the Maryland ma 23a or 28a-f show from the maryland ma 23a or 28a-f show from the maryland at the maryland part of the color.	7 SLADE AVENUE #2				21208			USA
Ind 21215-0036  be filled within 72 hours after death with the Marylan tal Hygiene. If other than "natural", or liema 23a or 28a-1 show event, the Medical Exercise must be indiffed at Be Completed by Funeral Director		2. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:	l'	Vas Decedent of N Yes, specify Cub	Hispanic Origin? (Spoan, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Specify	e - American Indian, sk, White, etc. :: WHITE
21215-01 ed within 72 ho vigene. Per than "nature to the Madical to the Madical to the Madical to the Madical Completed	15. Decedent's Educ (Specify only highest grade	cation	16a. Deced	lent's Usual Occup	pation	ina	16b. Kind of Bu	usiness/Industry
1215- within 72 within 72 one.	Elementary/Secondary (0-12)	College (1-4or 5+)			during most of work	ing .	OUN HOM	ır
d 21 d 21 filled w Hygien other th			HUMEI	MAKER	18. Mother's Name	/First Middle	OWN HOM	
	LITE I TANA		ABRAN	MSON	SARAH	o (* #3t, finadio,	maiden obmani	LEGUM
re, Maryla re, Maryla s 1 and 2 should Health and Men item 27 is marke other treumetic	19a. Informant's Name/Relationship (Type	oe, Print)			and Number or Rura	al Route Numbe	r, City or Town,	
M; Mand 2 and 2 salth a salth a lar tree	WILLIAM KARPA / S					BETHES	DA, MD	20817
Baltimore, bentil Pages 1 a Department of Hes Important: If item many injury or othe angles.	20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □R	emoval from State	<ul> <li>b. Place of Disposemetery, cren</li> </ul>	sition (Name of natory or other pla	(ce)	Date	20c. Location -	City or Town, State
ti Pa	' 4 □ Donation 5 □ Other (Specify)	E			PARK 05/1			ALLSTOWN, MD
Baltimore, M. Baltimore, M. permit. Pages 1 and 2 Department of Health a Important: If item 27 is any jointy or other tre	21. Signature of Funeral Sange License	luttle	89	Name and Addre	TERSTOWN F	ROAD - P	IKESVIL	OS., INC. LE, MD 21208
	23a. Part1. Enter the disease, or complication shock, or heart failure. List only on	eations that caused the decause on each line.	eath. Do not ente	er the mode of dyi	ng, such as cardiac o	or respiratory an	est,	Approximate Interval Between Onset and Death
Physician /Medical	Immediate Cause (Final disease or condition resulting in death)	Stroke						weily
Examiner		Due to (or as a cons	sequence of):					
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons	sequence of):		*****			
D, executed in and ial-transit	Cause (Disease or injury that initiated events resulting in death) Last							
68760, firate be executed physician and is the burial-transit edical Examin		Due to (or as a cons	sequence of):					
68760, ificate be experiment by the solicition as the burial edical Experiment edical Experiment.	d							
Box 6E  beath certifica a attending pt for use as ti	IF FEMALE: 23b. Was decedent pregnant 23	3c. If yes, outcome of pre					23d. Date	e of delivery
S, P.O. Box es that the death cert igned by the attendin be detached for use in	in the past 12 Tonths? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1□Live birth 2□F 4□Pregnant at time o 9□Unknown		Ectopic pregnancy Other (specify)	у		Mor	•
IS, P.C res that the signed by t be detach by Phy	Part II. Other significant conditions con	tributing to death but not	resulting in the ur	derlying cause giv	ven in Part I.	23e. Did to	bacco use contr	ribute to the cause of death?
Cords  * require been signald is should is		tra				1 🗆 Y	es 2 No	3 ☐ Probably 4 ☐ Unknown
Division of Vital Records, I or Attending Physician: The law requires that after death. Director: After this certificate has been signed in by the funeral director, page 2 should be ertification: To Be Completed by						24a. Was a autop:	ned? d	Vere autopsy findings available prior to completion of cause of leath?
f Vital Reysician: The is cardificate his director, page	25. Was case referred to medical				26. Place of Death		/	Yes 2 No
of Vi		<del></del>	ER/Outpatient	3 □ DOA Oth	ner: 4 Nursing Ho	me 5 Resid	ence 6 the	er (Specify) Hospice
Sion o tending Ph leath. tor: After th the funeral		28a. Date of Injury (Month, Day Year	28b. Time of Injury	28c. Injui	rk?	28d. Describe h	ow injury occurre	ad
risio Attendi death. ctor: A	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - A	t home farm stre		Yes 2 □No	28f Location /S	reat and Number	er or Rural Route Number,
Division cute or attending Parts after death. The Director: After fied in by the tuners Certification:	4 Homicide determined	building, etc. (Spe	ecify)	ot, lactory, office		City or Town	n, State)	w or runar rioute runniber,
Division of Vital Records, P.O. Box 68760, To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Medical Certification: To Be Completed by Physiclan/Medical Examilian		ician: To the best of my ler: On the basis of exam and manner stated.	knowledge, death ination and/or inv	occurred at the tile estigation, in my o	me, date and place, a opinion, death occurr	and due to the c ed at the time, d	ause(s) and mar ate and place, a	nner as stated. and due to the cause(s)
To the within To the comple	29b. Signature and title of certifier	A		29c. Licens	se number	2	9d. Date signed	(Month, Day, Year)
9	1 VIlla	$\mathcal{N}_{\mathcal{M}}$	$\supset$	DO	3303	V	MAY	11 2005
6	30. Name a d address of person who con	mpleted cause of death (I	tem 23a) (Type, f	Print)	1.00100	Can Pan	04	11 2005 2 WD 21204
State	31. Date filed (Month, Day, Year)	32 Registrar's Signature	gnature	-10/0	works.	12	u, vin ce	7007 -1
Registrar	MAY 1 6 200	5 Sergues	J. Ac					

			For State Registrar	State of M	arylan		artmen			and M	_	_			
	Oh., siei		Decedent's Name (First, Middle				Timout	0 01 1	<u> </u>		2. Date of De	ath Day	<del>! U Q</del>	ear	3. Time of Dealth
	Physici /Medic		Horold L	. Lewis							Mon	13	20	05	10:06 AM
	Examin	er	4a. Facility Name (If not institution	17	Made	Will Com	4b. City,	Town, or	Location of	of Death	t	4c.	County of	Death	
	Funeral		5. Social Security Number	6. Sex 7. Ag	e (In yrs.	last birthday	) If Under		If Under:		8. Date of Bin	th	9	. B <u>i</u> rthpla	ice (State or Foreign
b	Director		218-64-4252	1₾M 2□F		51 Yrs.	Months	Days	Hours	Min.	(Month, Da 4 – 16 -	- 5 <b>4</b>	V	A	γ)
	and w		Usual Residence of Decedent  10a, State 10b, County		10c. Cit	y, Town or L	ocation							10	d. Inside City Limits
	Maryl -f sho ied a	tor	MD Balti	more		ndalk									1 ☐ Yes 2 No
	n the	Irec	10e. Street and Number				10f. Zip	Code				10g. Citiz	zen of Wha	at Counti	y?
	23a o	alD	2922 Liberty		pt.		212	222				USA			
	er des Items ner m	Funeral Director	11. Marital Status	12. Was Decedent Armed Forces? ried 1 ☐ Yes 2 ☐	Ever in U	.S. 13.	Was Deced	lent of Hi	spanic Orig n, Mexican	gin? (Spe , Puerto f	cify Yes or No Rican, etc.)	- 1	14. Race - Black, '	America White, et	
36	urs aft	by F	1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☐ Morced		NO.		1 ☐ Yes	2 <b>X</b> No	Specify:				Specify <b>B</b>	lac	k
21215-0036	filed within 72 hours after death with the Maryland Hygiene. wher than "natural", or tems 23a or 28a-f show ent, the Medical Examiner must be notified at	sted		t's Education st grade completed)		16a. Dece	edent's Usua s kind of wo	al Occupa	ation	t of workin	20	16b. Kir	nd of Busin	ness/Indu	ıstry
2	vithin ne.	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	life.	DO NOT us	se retired	)	O WOIKII	,y :	_			
	filed v Hygie other t	e Co	9th 17. Father's Name (First, Middle,	Last)		Bric	k Lay	yer	18. Mothe	r's Name	(First, Middle,		stru Sumame)	Cti	on
an	lid be lental ked o ic eve	00	Zerah Lewis	,							ckson				
Maryland	2 should be and Mental is marked craumatic even	-	19a. Informant's Name/Relations			19b. Mail	ing Address				Route Number	er, City or	Town, Sta	ate, Zip C	Code)
	and 2 ealth m 27 I		Harold Lewis	Jr. (son)	1		Gler						1206		
Baltimore,	permit Pages 1 and 2 should be filed within 72 hours after death with the Marylan Deparment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any in ury or other traumatic event, the Modeal Examiner must be notified at once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation			lace of Disp emetery, cre			θ)		ate		cation - Cit	•	m, State
를	armer armer orant in ury		<ul><li>4 □ Donation 5 □ Other (S</li><li>21. Signature of Funeral Service</li></ul>		Sac	cred			s of Facilit		3-05 Ley Ch		dalk		T
Ba	permit Depar- Impor- any in		1/erley	Chant							. Balt				
i i			23a. Part1. Enter the disease, in shock, or heart failure list	complications that cay be	the deat										Approximate nterval Between
Ш	Physician		Immediate Cause (Final disease or condition			mer		٩.						(	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a conseq	uence of):	9.00	и							1
		e	Sequentially list conditions, any, each gloom rocal cause. Enter Underlying Cause (Disease or injury	b. Human	a conseq	www.u/Muence if):	mush	in			_			-	anns
	cuted id ansit	Examiner	that initiated events	. Hubis	hhs	0								1 6	18115
ő,	cate be executed physician and the burial-transit	I Exa	resulting in death) Last	Due to (or as	a conseq	uence of):							-	1	1
8760,	icate b physic the b	Physiclan/Medical		d											
Box 6	death certifica attending ph for use as th	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome								2	3d. Date o	f delivery	,
	ires that the death cer signed by the attendin d be detached for use	icla	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown			⊒Ectopic pr ⊒ Other (sp						Month		ay Year
<u>Р</u> .	at the	Phys	9 Unknown			100									
ords,	w requires the been signed should be d		Part II. Other significant condition  H. W.	W UNUNT	mut not res	ulting in the i	anderlying c	ause give	en in Part I.			obacco us Yes 2		Te to the	cause of death?
Record	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Completed by							· · · · · · · · · · · · · · · · · · ·		24a. Was autop perio 1 Yes	osy /	24b. Wer prior deat 1 🗆	r to com; th?	sy findings available pletion of cause of
Vita	stifica ector, p	Be C	25. Was case referred to medica examiner?						26. Place	of Death	(Check only o			103 2	
)   	Physician: r this certifica ral director, p	2	1 ☐ Yes 2 No	Hospital: 1 Inpatie		ER/Outpatie		1	4 🗆 1401		ne 5 🗆 Resid			Specify)	
On O	ding h. h. After funer	tlon	27. Manual 5 Pendir		y Year)	28b. Time of Injury	of 2	8c. Injury Work	at :? /es 2.⊟h		8d. Describe h	now injury	occurred		
Division of	or Attending I after death. Director: After in by the funer	Certification:	2 Accident investig	not be 28e. Place of Inj	ury - At he	ome, farm, st				_	8f. Location (S	Street and	Number o	or Rural I	Route Number,
	ital or A rs after ral Directed in by	Cert	4 - Homicide	building, et	с. (Зресп	y) 				li.	City or Tov	vn, State)			
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	edical	29a. Certifier Check only one) Certifyir 2 Medical	ng Physician: To the best Examiner: On the basis o and manner st	f examina	wledge, dea tion and/or ir	th occurred ovestigation,	at the tim in my op	e, date and pinion, deat	d place, a th occurre	nd due to the d d at the time,	cause(s) a date and	and manne place, and	er as stat due to ti	ed. he cause(s)
	To the within 2 To the complete	Σ	29b. Signature and title of certifie	7			290	License	number		1	29d. Date	signed (A	fonth, Da	ay, Year)
•			Myrey	2 WVD	4 **		K	KD	- 00	10		viau	15	2	<i>UU</i> 5
			30. Name and address of person	who completed cause of c	leath (Iten	1 23a) (Type	, Print) [MM]	2	altin	im	m	> 6	712	24	
•	Sta		31. Date filed (Nonth Day, Year)		ar's Signa	ture	1		~ -11//		1-1		10	1	
	Registr	ar	mrs I	6 2005	wor	15	9294E	1							

State of Maryland / Department of Health and Mental Hygiene [ ] [] 5 For State Registra Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Day 2005 Year **Physician** 13, May Doris Ann 3:45 A Leap /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Holland Manor Assisted Living Towson Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | July 14, 1933 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) Funeral 1□M 2□ F Yrs. New York Director 122-24-8342 71 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show other traumatic event, the Madical Examiner, ust be notified at Director 1 ☐ Yes 2 No Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ or Items 23a 1812 Landrake Road 21204 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 X Widowed 4 □ Divorced "natural" 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th Grade Licensed Practical Nurse Nursing Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Cyrus Leap Semerad Anna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health at Important: If item 27 is any injury or other travence. Phyllis Gray (friend) 1516 Chesaco Ave., Baltimore, MD 21237 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Commation 3 Removal from State comments, crematory or other place)
4 Donation 5 Dother (Specify) Entombment Druid Ridge Mausoleum 5/16/05 Baltimore, Maryland 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of Funeral Service Licensee 9705 Belair Rd., Baltimore, MD 21236 ane 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ATH EROSCHEROTIC Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 125 IRDET 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Be Completed STEOPOROSIS 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2**X** No 1 ☐ Yes after death.

Director: After this certification by the funeral director, p 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 AOther (Specify) Luving examiner' 1 🗌 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type,

State Registrar 31. Date filed (Month, Day, Year) MAY 1 6 2005

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month **Physician** dis /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Fecitit Neme (If not institution, give street and number) Examiner If Under 1 Year Under 24 Hrs 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthptace (State or Foreign Country) **Funeral** Days Months Hours 1□ M 2√XF Yrs. 79 220-14-2095 Director Usuel Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at XXYes 2□No Director MD NA Baltimore 10e. Street end Number 10f Zip Code 10g. Citizen of Whet Country? 2419 West Lafavette Ave 21216 U.S.A. death v Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify. ğ XXWidowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)
Long Term Substitute 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Teacher Baltimore City 12th grade 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown Be Pages 1 and 2 should be nent of Health and Mental Is marked Cora Parker 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If Item 27 I Lynette Locke-Daughter 2307 Calverton Heights Ave, Balto, Md 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 5/16/05 Baltimore, Md 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
March F/H West 4300 Wabash Ave, Baltimore, Md 21215 Perf. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner as the burial-transit The law requires that the death certificate be executed Sequentiatly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events P.O. Box 68760 Physician/Medical Due to (or as a consequence of) resulting in death) Last usa Part II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 4 Unknown Š 3 Probabty 1 Yes 2 No Division of Vital Records. Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Pes 2 🗆 No 1 ☐ Yes 2 ☐ No or Attending Physician: Be 26. Place of Death (Check only one) examiner? Hospitat: 1 patient 2 □ ER/Outpetient Other: ဥ 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Dale of Injury (Month, Day Year) nner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 ☐ Pending death. investigation 1 ☐ Yes 2 ☐ No Director: A 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide To the Hospital within 24 hours a To the Funeral C completaly filled filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D

State

			1 - For State Registrar	State of Maryla	nd / Depa			Mental Hyg	-	0 5	16382
	Physic /Medi		1. Decedent's Name (First, Middle, La Della La	ne.ne				2. Date of Dea Month May	Day	Yeer 2005	3. Time of Death 8:04 A
	Exami		5. Social Security Number 6. S	ex 7. Age (In yrs	ed Centr last birthday)			8. Date of Birth		ltimor	e City e (State or Foreigi
	Director	tor	Usual Residence of Decedent  10a. State  10b. County	/5	Yrs.	cation	en Burnie	Jan 5,	1930	10d.	KY Inside City Limits 1 □ Yes ※XXNo
	ith with the 23s or 28s-	al Direct	10e. Street and Number  920 Andrews Ro			10f. Zip Code		1	Og. Citizen of V		?
920	within 72 hours after death with the Maryland ene. than "naturel", or tems 23e or 28e-f show fre Madical Examirer must be notified at	d by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ▓ Divorced	12. Was Decedent Ever in the Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates:	l l	Was Decedent of f Yes, specify Cu 1 ☐ Yes 2X No	Hispanic Origin? (Saban, Mexican, Puerto Specify:	pecify Yes or No- o Rican, etc.)		e - American k, White, etc.	Indian,
21215-0036	within 72 h iene. than "natu i'e Modical	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed)  College (1-4or 5+)	16a. Deced (Give life. L	lent's Usual Occi kind of work don OO NOT use retir	e during most of wor red)	king	16b. Kind of Bu	siness/Indus	,
힏	should be filed withing the Mental Hygiene.  marked other than umatic event, I'le M	To Be C	17. Father's Name (First, Middle, Last) McKinley Jones				18. Mother's Nar	ne (First, Middle, M	Maiden Surnam		ance
Z Z	s 1 and 2 sho f Health and item 27 Is ma other treum		19a. Informant's Name/Relationship (  Ms. Mary Carr /  20a. Method of Disposition	daughter 20b.	29		er Brook (	Court, F	City or Town, Casadena	a, MD	21122
Baltimore,	perriit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel; or items 23a or 28a-f show any njury or other treumatic event, If a Marical Examinat must be notified at once.		1 Burial 2 Cremation 3 C 4 Donation 5 Other (Specification 21. Signature of Funeral Service Licer	C)	hesapea	ke Crema . Na <i>m</i> e and Add	ation 20		ton Fur		Home, P.
	death certilicate be executed e attending physician and to use as the burial-transit	Ical Examiner	23a. Part. Ener the disease, or com, shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter orderlying Cause (Disease or injury that initiated events resulting in death) Last	one cause on each line.	quence of):	er the mode of dy	200	or respiratory arre	est,	Int	proximate lerval Between set and Death
P.O. Box 68	death certific e attending p d for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 6	al death 3 🗆	Ectopic pregnan Other (specify)	су	11.33	23d. Date Mon	of delivery oth Day	y Year
rds, r	Ine law requires that the ate has been signed by the page 2 should be detache	by	Part II. Other significant conditions o	ontributing to death but not re	sulting in the un	derlying cause g	iven in Part I.		acco use contri		
		Completed						24a. Was ar autopsy perform 1 Yes 2	red? p	Vere autopsy rior to comple eath?	findings available etion of cause of No
ion or vital	anng rnys n. After this funeral di	atlon; To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigation	Hospital: 1 Impatient 2 2 28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. Inju	ther: 4 🗆 Nursing H	th Check onl one ome 5 Reside 28d. Describe ho	nce 6 □Othe	or (Specify)	
DIVISION	onal or Autono urs after death oral Director: illed in by the	Certification:	3 Suicide 6 Could not be determined	building, etc. (Speci	fy)			28f. Location (Str City or Town	State)		
	within 24 hours at To the Funeral D completely filled i	Medical	one) 2 Medical Exam	ysicien: To the best of my known iner: On the basis of examination and manner stated.	owledge, death ation and/or inv	estigation, in my	opinion, death occur	and due to the ca red at the time, da	use(s) and <i>m</i> ar te and place, a	nner as stated nd due to the	i. cause(s)
1	within Com	Σ	29b. Signature and itle of certifier	mp			18600		May		
-	1			eene St.	т 23a) (Туре, F BN K'	erint)	18600 MD, 21	201.	Jeffn	ey lic	i, MD
	Sta <b>Reg</b> istr	-	31. Date filed (Month, Day, Year) MAY 1 6 21	32 legistrar's Signa	ture Los	W.				U-	

		•	For State of Registrar	•	artment of Health and N tificate of Death	lental Hygie Reg.	71115	16383
	9		Decedent's Name (First, Middle, Last)			2. Date of Death	Day Year	3. Time of Death
	Physici /Medic		Dennis John Lafferty			May 8, 20	05'	9:04 P M
	Examin		4a. Facility Name (If not institution, give street and nurr 6206 McClean Blvd.	aber)	4b. City, Town, or Location of Death Baltimore		4c. County of Deat	h
	Funeral Director		5. Social Security Number 6. Sex 190-22-8430	7. Age ( <i>In yrs. last birthday</i> ) 75 Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Ye		hplace (State or Foreign untry) New York
			Usual Residence of Decedent			June 19,	1929	NEW TOTK
	irylan ihow	_	10a. State 10b. County	10c. City, Town or Lo				10d. Inside City Limits
	Ba-f e	Director	Maryland N/A	Bali	timore	11		1 ☐ Yes 2 ☐ No
	with the or 2		10e. Street and Number 6206 McClean Blvd.		10f. Zip Code 21214	10g.	United S	100
	death ms 23	Funerai	11. Marital Status 12. Was Dece	dent Ever in U.S. 13. y	Vas Decedent of Hispanic Origin? (Sc	ecify Yes or No-	14. Race - Ame	rican Indian,
36	d within 72 hours after death with the Maryland jiene. r than "natural", or Items 23a or 28a-f ahow The Medical Evaninat must be rolliked at	by Fur	Armed For  1 Never Married 2 Married 1 Yes, Giv.  3 Midwed 4 Divorced Year or Da	2 X No	f Yes, specify Cuban, Mexican, Puerto I □ Yes 2፟፟፟፝ No <i>Specify:</i>	Hican, etc.)	Specify:	e, etc. Ihite
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Maryland 21215-0036	d tal	To Be	Samuel Lafferty		Margar		_	
lary	2 should and Men la marke raumatic		19a. Informant's Name/Relationship (Type, Print)		g Address (Street and Number or Ru			Zip Code)
di	and tealth m 27 her te		Michael H. Lafferty / Bro	20b. Place of Dispo-	8 E. Linvale Dr.	Aurora, (	. Location - City or	Town, State
altimore,	Pages ent of nt: If it ry or o		1 ☐ Burial 2 【Cremation 3 ☐ Removal from S `4 ☐ Donation 5 ☐ Other (Specify)	State	natory or other place) Service Corp. 5/1	3/2005	Towson, M	laryland
alti	permit. Pages 1 Department of H Important: If ite any injury or ot once.				. Name and Address of Facility		05 Harfor	
<b>B</b>	20129		Mill Caly of		Leonard J. Ruck,		ltimore,	
			23a. Part1. Enter the disease, or comblications that cannot shock, or heart failure. List only one cause on example the shock of the sh	ach line.	er the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
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	neit neit	nine	rf any, leading to immediate cause. Enter Underlying Cause (Disease or injury	or as a consequence of).				
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8760,	cale be executed physician and the burial-transit	dicai	d					
Box 6	eath certifi attending for use as	Φ.		come of pregnancy	Tr		23d. Date of del	ivery
	The law requires that the death certificate has been signed by the attending I agge 2 should be detached for use as	Physician/M		ant at time of death 5	Ectopic pregnancy Other (specify)		Month	Day Year
P.0	that the		Part II. Other significant conditions contributing to de	ath but not resulting in the ur	nderlying cause given in Part I.	23e. Did tobac	co use contribute to	the cause of death?
rds	quires n sign uld be	ed by	SICK SINUS S	YNDROME		1 ☐ Yes	2 □ No 3 □ Pr	obably 4 Inknown
Vital Records,	law requir as been si 2 should	Completed	PROSTATE CANC	ER		24a. Was an autopsy	prior to o	topsy findings available completion of cause of
E B		Com				performed 1 ☐ Yes 2 ☑	death?	
VIII:	Physician: The this certificate ral director, page	Be	25. Was case referred to medical examiner? Hospital:		Other	th (Check only one)		
of		n; To	27. Manner of Death 28a. Date	npatient 2 ER/Outpatien of Injury 28b. Time of th, Day Year) Injury	28c. Injury at	ome 5 Aesidence 28d. Describe how i		cify)
sion	Attending I death. ctor; After y the funer	atio	2 Accident investigation	h, Day Year) Injury	Work? M 1 □ Yes 2 □ No			
Division	l or Attend after death Director: ,	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place building	of Injury - At home, farm, str ng, etc. <i>(Specify)</i>	eet, factory, office	28f. Location (Stree City or Town, S		ıral Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director; Afte completely filled in by the fune	edical C	(Check only 2 Medical Examifter: On the ba	asis of examination and/or in	n occurred at the time, date and place, vestigation, in my opinion, death occu	red at the time, date	and place, and due	
	To the within ? To the comple	Med	29b. Signature and title of certifier	ner stated.	29c. License number	29d.	Date signed (Monti	h, Day, Year)
	~		· 1 m	X	D37280	0.	5/12/0	5
10			30 Name and ad less is person who completed caus JERALD TNSEL, M.J.	of death (Item 23a) (Type, 5601 LOC	29c. License number D37280 Print) RAVEN BLVA.	STE.206	BALTO.	MD. 21239
	Sta Regista		31. Date filed (Month, Day Agar) 1 6 2005 32. R	sustrar's Signature	Sperke	,		
	ricgial	-EII						

			State of Maryland / Department of Health a  1 - State Registrar  Certificate of Death	and Mer		iene	)5	16384
	Physici	<b>an</b>	1. Decedent's Name (First, Middle, Last)		Date of Death Month		'ear	3. Time of Death
	/Medic		Harvey Calvin Meek		May	12, 200		10:50P M
	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Tows on	of Death		4c. County of		t o
			5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 2	24 Hrs.   g	Date of Birth			
	Funeral Director		213-26-5255 12 M 2 F 75 Yrs. Months Days Hours	Min.	Date of Birth (Month, Day, au 27.	1929 N	Coun	place (State or Foreign htty) Land
	_		Usual Residence of Decedent	,,,,	octy 215	.,_,,		
123	trylan show	_	10a. State 10b. County 10c. City, Town or Location				1	0d. Inside City Limits
23	8a-1	Sc to	Maryland Harford Forest Hill			- 0111 (118		1 □ Yes 2 No
Intos 10:50 pm	with the Maryland a or 28a-f show be notified at	Funerai Director	106. Street and Number  2095 Brandu Drive  21050		10	0g. Citizen of Wh	at Coun	itry?
100	s 23	erai		igin? (Specify	Yes or No-	14. Race -		an Indian.
5	fter d	Fun			an, etc.)		White,	etc.
036	ei', o	þ	1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced Year or Dates Conflict			Specify:	W	rite
21215-0036	within 72 hours after 6ne. then "neturei", or Ite ne Madical Examina	Completed	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most life. DO NOT use retired)	t of working		16b. Kind of Busi		·
€ 22	within ne. hen.	m jg	Elementary/Secondary (0-12)   College (1-4or 5+)			Hemmingv Trucking		
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an	d be antai	To Be		Marie		.6man		
###	should Mind Mind Mind Mind Mind Mind Mind Min	-	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number	er or Rural Ro	oute Number,	City or Town, S	ate, Zip	Code)
Z	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Heelth and Mental Hygiene. Important; if Item 27 is marked other then "neturel", or Items 23a or 28a-1 show any injury or other traumatic event, the Mardical Examination is not been allied at ODEs.		Mrs. Doris M. Meek (wife) 2095 Brandy Drive,	, Fore	st Hil	l, MD 1	2105	0
ore,	of He of He fitem r oth		20a. Method of Disposition  1      XBurial   2 □ Cremation   3 □ Removal from State   20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	2	20c. Location - C	ity or To	wn, State
Meel Baltimore	Pag ment ant; i		'4 □Donation 5 □Other (Specify)   Gardens of Faith Cem. 5					
Æ3alt	Depart Depart Mport any in		21. Signature / Funeral A trute Licensee 22. Name and Address of Facility					
	0.03 e a		9705 Belair Rd.			·	236	Approximate
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as a shock, or heartfailure. Ust only one cause on each line.		sspiratory arre	751,		Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a.   An Creatic Canculation Canculati	/ <b>&gt;</b>			-	months
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1760,	e exe cien a urial-l		resulting in death) Last Due to (or as a consequence of):					
	cate b	dicai	d				-	
Box 68	death certificat e attending phy ed for use as th	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date	of delive	arv.
Bo	atten atten for u	cian	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No  4 ☐ Pregnant at time of death 5 ☐ Other (specify)			Mont		Day Year
P.O.	0 0 0	hysi	9 Unknown					
	The law requires that the dei ste has been signed by the a bage 2 should be detached fo	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tob	acco use contrib	ute to th	he cause of death?
rd	v require been sig should b				1 □ Ye	s 2/1 No 3	Prob	oably 4 Unknown
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<u>~</u>	The zate h page	Completed			perform 1 Tes 2		ath? ] Yes	2 No
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	To the Hospital or Attending Physicien: The law requir within 24 hours after death.  To the Funeral Director: After this certificate has been s completely filled in by the funeral director, page 2 should	Medicai	29a. Certifier  (Check only    Medical Examiner: On the basis of examination and/or investigation, in my opinion, deal					
	o the o the omple	Mec	one) and manner stated.  29b. Signature and little of certifier 29c. License number		29	9d. Date signed (	Month,	Day, Year)
	- * F. 3		DS83	303	i	MAY 13	2	005
	-11		30. Name/and address of person who completed cause of death (Item 23a) (Type, Print)  AAA()\(\text{VWMLE}\) \(\text{WMLE}\) \(\text{VM}\) \(\left(260)\) \(\text{VWMLE}\) \(\text{VM}\)	- A	0 4	5	0 -	2 (2 (2 )
5	1			1)0	ulte	uz m	V	-1204
	Sta Regist		31. Date filed (Month Day, Year) 2005 33 Registrar's Signature					

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 11 20 11 Leonora Bertha McManus /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4h City Town or Location of Death **Examiner** Chapel Road VINCE old Beres 6 corge 5 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5 Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 ☐ M 2 ☐ XF Yrs 79 216-22-0625 March 26,1926 Maryland Director Usual Residence of Decedent the Maryland 10c City Town or Location 10d Inside City Limits 10a State 10h County 28a-f ehow traumatic event, the Medical Examinat must be notified at 1 X Yes 2 ☐ No Director Prince Georges Bowie 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? with ò 14001 Old Chapel Road 20720 USA Items 23a death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 XNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if item 27 is marked other than "netural", or ten any injury or other traumatic event, the Medical Example once. Black, White, etc. 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 2 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Telephone Company Teller 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Vincent Fladung Magdalene J. Mack 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) John E. Mullikin, Jr./ Cousin 13217 Pine Road Bowie, MD 20720 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Ascension Cemetery 5/16/2005 Bowie, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Service Lice 16000 Annapolis Road Bowie, MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Athensederatio Cardovesular Heart Diseas Immediate Cause (Final Pnysician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to for as a consequence of: Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last certificate be executed use as the burial-transit Due to (or as a consequence of): Box 68760, the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year for Day 4 Pregnant at time of death 5 Other (specify) P.O. detached been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, à page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 2 No 2 No 1 Yes Hospitel or Attanding Physician: 24 hours after death. 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1- Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA this Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation М 2 Accident Director 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely (Check only one) and manner stated. ro tha within 2 To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 300/ Hos 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 1 6 2005 Registrar

			1 - For State Registrar	State of Ma	ryland / Dep <i>Ce</i>	artment of rtificate o		Mental Hy	giene Reg. No. 200	16386
	Dharini		1. Decedent's Name (First, Middle, Last)					2. Date of De		3. Time of Death
	Physici /Medio		Raymond Vernon Mul	nl Sr.					12 2005 Yea	8:11 A M
	Examin	er	4a. Facility Name (If not institution, give s	treet and number)			, or Location of De	ath	4c. County of De	
			401 Second Street  5. Social Security Number 6. Sex	7 470	(In yrs. last birthday		ce City	rs. 9 Date of Bir	Worces	
	Funeral Director				33 Yrs.	Months Day			year)	Sirthplace (State or Foreign Country) MD
			Usual Residence of Decedent							
	rylan	_	10a. State 10b. County		10c. City, Town or L					10d. Inside City Limits 1 ☐ Yes 2X No
	Ba-f s	cto	MD Worcester		Pocomoke					
	vith th	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?
	s 23s	Funerai	401 Second St.	12. Was Decedent E	vor in 11 S 13	2185		(Specify Ves or No	USA	nerican Indian,
	fter d	Fun	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces?	0			(Specify Yes or No erto Rican, etc.)	Black, Wi	
036	al', or		3 X Widowed 4 □ Divorced	1 XYes 2 □ N If Yes, Give Year or Dates:		1 □ Yes 2 🗓 N	o Specify:		Specify:	white
21215-0036	within 72 hours after death with the Maryland ane. than "natural", or Items 23a or 28a-f show ta Madical Exeminer must be multied at	Completed by	15. Decedent's Educ (Specify only highest grade	cation completed)	(Giv	edent's Usual Occ	ne durina most of w	vorking	16b. Kind of Busines	ss/Industry
21	han "	mple	Elementary/Secondary (0-12)	College (1-4or 5-	life.	DO NOT use reti Velder	red)		Nevm	ar
2	filed w Hygien other ti		8 17. Father's Name (First, Middle, Last)		v	verder	18 Mother's N	ame (First, Middle	, Maiden Sumame)	
anc	d be f	o Be	Conrad	Muh1				becca	Meter	
Maryland	2 should be filed withir and Mental Hygiene. is marked other than sumatic event, the M.	P <sub>C</sub>	19a. Informant's Name/Relationship (Ty)		19b. Mail	ing Address (Stre			er, City or Town, State	. Zip Code)
	nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan crannent of Heath and Mental Hygiene. ortant: If item 27 is marked other than "natural", or Items 23a or 28a-f show injury or other traumatic event, I're Madical Examinat must be nutified at a.		Mr. Raymond V. Muh	1 Jr. / se	on 401	Second S	t. Poco	moke City	MD 21851	
Je,	of Health item 27 I		20a. Method of Disposition		20b. Place of Disp cemetery, cre	osition (Name of amatory or other p	lace)	Date	20c. Location - City	or Town, State
Ē	Pages nent of ant: If its ary or o		1 XBurial 2 ☐ Cremation 3 ☐ R 1 4 ☐ Denation 5 ☐ Other (Specify)	emoval from State	Louden P			17/05	Baltimore,	MD
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr Q059.		21. Signature of Funeral Service Licens			22. Name and Add	ress of Facility Ave SW G	Singletor Len Burni	Funeral H Le MD 21061	lome P.A.
			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused le cause on each lin	the death. Do not er	nter the mode of d	ying, such as card	iac or respiratory a	rrest,	Approximate Interval Between Onset and Death
760,	death certificate be executed with the physician and be attending physician and a for use as the buriar-transit	ical Examiner	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause for the death of the death o	Due to (or as a	consequence of): consequence of):		MUCER			
.O. Box 68	res that the death certifica signed by the attending ph I be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 □ Live birth 24 □ Pregnant at 19 □ Unknown	2 Fetal death 3.	□Ectopic pregnal			23d. Date of o	lelivery Day Year
rds, P	quires that n signed t	by	Part II. Other significant conditions cor	tributing to death bu	t not resulting in the	underlying cause	given in Part I.			to the cause of death? Probably 4 Dunknown
Record	The law requires that the ste has been signed by the bage 2 should be detache	Completed	<u>                                     </u>					24a. Was auto perfo	psy prior t ormed? death	
Vital	ysician; The is certificate hadirector, page	Bec	25. Was case referred to medical examiner?				26. Place of D	eath (Check only	one)	
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isi	Attending or death. sector: Atterby the fune	icat	2 Accident investigation 3 Suicide 6 Could not be	29.0 Place of Inju	ry - At home, farm, s		Yes 2 No	28f Location (	Street and Number or	Rural Route Number
Division	l or Attence after death Director:	Certification:	4 Homicide determined	building, etc	. (Specify)	noor, radiory, onic			wn, State)	
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical C	29a. Centifier 1 Certifying Physical Check only 2 Medical Examinate	sician: To the best of her: On the basis of and manner stat	examination and/or i	ith occurred at the	time, date and pla y opinion, death oc	ce, and due to the curred at the time,	cause(s) and manner date and place, and d	as stated. ue to the cause(s)
	To th Within To th	Me	29b. Signature and title of certifier		4.5	29c. Lice	nse number		29d. Date signed (Mo	nth, Day, Year)
	d		1 Lethen 9	nuton.	110	H	005371	4	5/12	105
1			30. Name and address of person who co	mpleted cause of de	eath (Item 23a) (Type	Print)		•	1 1	
	<i></i>		Jeffrey Matza		314 Fram	LLIN M	re Sink	302 (	berlin mo	21811
	Sta Regist		31. Date filed (Month, Day, Year)		r's Signature	books				

			S	State of Marylan				_	_	
			For Stete Registrar	rate of marytan		tificate of			Reg. No. 0 0 5	16387
			Decedent's Name (First, Middle, Last)					2. Date of De Month	ath Day Year	3. Time of Death
	Physici /Medic		Bruce Merrill McLa	ane				May 11	, 2005	12:59P M
	Examin		4a. Facility Name (If not institution, give stre			4b. City, Town, o		Death	4c. County of Dea	
			Shady Grove Advent: 5. Social Security Number 6. Sex	ist Hospital 7. Age (In yrs.		Rockvil If Under 1 Year		Hrs. 8 Date of Bird	Montgome	
	Funeral Director			2□ F 55	Yrs.	Months Days	Hours	Min (Month, Da	Vear) 1950 Per	thplace (State or Foreign ountry) nnsylvania
	ס		Usual Residence of Decedent							
	show	2	10a. State 10b. County		ty, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	the M	Director	Maryland Montgomery  10e. Street and Number	y Ch	evy Ch	ase 10f. Zip Code			10g. Citizen of What C	
	3a or		4405 Walsh Street			2081	5		United Sta	
	death	Funeral		Was Decedent Ever in U Armed Forces?	.S. 13.			n? (Specify Yes or No Puerto Rican, etc.)		erican Indian,
98	or Ite	y Fu	1 Never Married 2 Married	1 ☐ Yes 2 X No If Yes, Give		1 ☐ Yes 2 <b>X</b> No		r dono i nodini otori,	Specify:	
Maryland 21215-0036	within 72 hours after death with the Maryland ene. then "natural", or Itema 23a or 28a-f show f.a. Medical Exar, it at roual be notified at	ed by	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Educat	Year or Dates:	16a Decer	dent's Usual Occup	nation			nite
<u>.</u>	in 72 n "na Nedic	plet	(Specify only highest grade of Elementary/Secondary (0-12)	ompleted)	(Give	kind of work done DO NOT use retire	during most of	of working	TOD. TAIL OF DUSINESS	villadatiy
212	d with glene er tha	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) 5+	Adve	rtising	,		The Washir	ngton Post
nd	be file tal Hy d oth	Be (	17. Father's Name (First, Middle, Last)					s Name (First, Middle,		
yla	ould     Meni	၉	Merrill Freeman Mc		405-14-75			ene Orbaen		Zi- On da l
Mar	d 2 sh th and 7 Is m traum		19a. Informant's Name/Relationship (Туре, Claire McLane/Wife	Print)	1	-			er, City or Town, State, se, Marylar	
ō,	pernit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Deputrment of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Itema 23a or 28a-f show any injury or other traumatic event, If a Medical Ever, if at real be notified at another.		20a. Method of Disposition	20b. F	Place of Dispo	sition (Name of matory or other plan		ay 15,	20c. Location - City or	
mo	Pages ent of nt: If i		1 ☐ Burial 2 🕅 Cremation 3 ☐ Rem `4 ☐ Donation 5 ☐ Other (Specify)	noval from State Moi	ntgome	Lum, Inc.	2	005	Bethesda,	Maryland
Baltimore,	permit. Departmimporta any inju		21. Signature Funeral Service Licentee	, GF	Re	Name and Addre	ss of Facility	Robert A.	Pumphrey Fu	neral Home/ onsin Avenue
<u> </u>	825 8 8		Jan E	<b>999</b>	1803 Be	thesda,	Maryla	nd 20814-	3501	*
П			23a. Part1. Enter the disease, or complications shock, or heart failure. List only one	cause on each line.			-			Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Acute	W400	ardiaL	Intar	Ction	ſY.	dans.
ı	Examiner			Due to (or as a consect	quence of):	fam or		rtery Dis	SA SA	Years
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/	icuted nd iransit	Examiner	Cause (Disease or injury that initiated events							
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Box 6	The law requires that the death certifica ate has been signed by the attending phoage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 23c.	. If yes, outcome of pregn					23d. Date of de	livery
ĕ.	death e atte	lcia	in the past 12 months? 1 □ Yes 2 □ No	1 Live birth 2 Feta		Ectopic pregnanc Other (specify)	у		Month	Day Year
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Division	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification;	4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	fy)	eet, lactory, office		City or To	wn, State)	urai i toute rumber,
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	he Ho in 24 he Fu pletel	edical	(Check only 2 Medical Examine one)	r: On the basis of examina and manner stated.	ation and/or in			occurred at the time,		
	With To t	Σ	29b. Signature and title of certifier	mas	2	29c. Licens			29d. Date signed (Mon	-
1			proton	111:00	21	D005	209	5	ןן דיינוען	2005
	20		Jonathan Wenk, M.D				ve. Ro	ckville, M	arvland 20	0850
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	_	. C , RO	unvaring H	aryrana Ze	
	Regist		MAY 1 6 20	05 Januar	Si A	Joseph				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Req. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Day Month Year **Physician** Eleanor Rose Markowski May 11, 2005 5:30 P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore City N/A FutureCare Canton Harbor If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days Hours 1 □ M 2 🛛 F Yrs. 89 Director 219-10-9704 19,1916 Maryland Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show traumatic avant, the Medical Examiner must be notified at 1 ☐ Yes 2X No Dundalk Director Maryland Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21222 1715 Pin Oak Avenue itams 23a United States death v Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: if itam 27 is marked other than "natural", or itar may injury or other traumatic avant. The Mcdical Examinations. Black, White, etc. ☐Yes 2☐No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2000 Specify: If Yes, Give Year or Dates: Specify: à 3€Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Years Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Rose Purol ပ Frederick Emala 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type, Print) 21222 Baltimore, Maryland 1715 Pin Oak Ave. (Daughter) Barbara Moran 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State fX Burial 2 ☐ Cremation 3 ☐ Removal from State Dundalk, Maryland Sacred Ht. of Jesus Cem. 5/14/2005 4 □ Donation 5 □ Other (Specify) Funeral Service License 21. Signatur 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 21222 7922 Wise Ave. Dundalk, Maryland 23a. P.m.1. Enter the disease, o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ASCVO Pnysician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease of injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate ba executed burial-transit 0580 Due to (or as a consequence of): Box 68760, physician Physician/Medical the as the attending IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by pe 4 Unknown 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate has autopsy perform 1 ☐ Yes Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 SNo 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Dath 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Hospital or Attending 5 Pending after decth. 1 ☐ Yes 2 ☐ No Accident investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide To the Hospital within 24 hours a To the Funaral D 15 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of extifier 5.1200 14276 30. Name and address of person who comple Simon Scalia, M.D. rson who completed cause of death (Item 23a) (Type, Print)
ia, M.D. 2801 Hudson Street Baltimore, Maryland 21224

Registrar

31. Date filed (Month, Day, Year)

MAY 1 6 2005

32. Restrar's Signature

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1 Decedent's Name (First, Middle, Last) Month **Physician** May 14. 2005 2:05 A. Wheeler Mvers Thomas /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Gilchrist Center Baltimore County Towson Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year April 29, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year) Months 1 X M 2 ☐ F 61 1944 Maryland Director 218-46-0154 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County itam 27 la marked other than "natural", or Itama 23a or 28e-f show other traumatic avant, It a Madical Exacilitat over the Italiad at Baltimore City 1 Yes 2 No Maryland N/A Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 2608 Roselawn Avenue 21214 Funerai 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) □Yes 2 No Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White Completed by 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7 th and Mental Hygiene. 7 Is marked other than "r College (1-4or 5+) Elementary/Secondary (0-12) 12 Millwright Bethlehem Steel 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Frederick Francis Mvers Mary Agnes Reillv 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltimore, MD 21214 Mrs. Eleanor A. Myers - Wife 2608 Roselawn Avenue of Health 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any injury or o 1 Burial 2 □ Cremation 3 □ Removal from State

'4 □ Donation 5 □ Other (Specify) May 18,2005 Marriottsville, MD Crestlawn Cemetery Paul L. Hartsock, Jr. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Baltimore, Maryland 21214 Inc. 5305 Harford Rd. Leonard J. Ruck, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Bile Dact Circo eass /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physician Physician/Medical use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day ó in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 4☐Pregnant at time of death detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s certificate has autopsy 1 ☐ Yes 2 ☐ No 20 No To the Hospitel or Attending Physicien: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 25 No Hospice this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification; 1 Natural 5 Pending investigation after death.
I Diractor: Aff
d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funeral I Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified D0051926 (يىر) Maci 6601 N. Charles Street 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Goodan M. wo Towson, MD 21204 32. Pagistrar's Signature 31. Date filed (Month, Day, Year) State MAY 1 6 2005 Registrar

DHMH 17 Rev 1/2001

lhomas Myers May 14,2005

State Registrar 30. Name and addre

of person

31. Date liled (Month, Day, YeaWAY 16

RIPPL

111 Penn Street

Baltimore, Maryland 21201

completed cause of death (Item 23a) (Type, Print)

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		1 - For State Registrar	State of Mai	ylanu	•	cate of			Reg. No.2 0 0	5 16391
		1. Decedent's Name (First, Middle, Last)				* **		2. Date of De		3. Time of Death
Physicia /Medic		Mary Eileen McGinn						May	10 2	005 9:00 P M
Examin		4a. Facility Name (If not institution, give s		tor		City, Town, o Parkvi	r Location of Death		4c. County of Baltin	
		Oak Crest Village  5. Social Security Number 6. Sex				Under 1 Year		8. Date of Bir		Birthplace (State or Foreign
Funeral Director		212-09-4108	M 2(X)F	87		onths Days	Hours Min.	June 1.	iv, Year)	Mary Land
and		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Location	n				10d. Inside City Limits
e-f sho	Director	Maryland Baltimo	re	Pa	rkville					1 ☐ Yes 2XX No
er 28	Olre	10e. Street and Number			1	Of. Zip Code			10g. Citizen of Wh	at Country?
23e	a	8800 Walther Blvd.				21234			United	
tems	Funeral	Tr. Wartar States	<ol><li>Was Decedent Ev Armed Forces?</li></ol>		13. Was	Decedent of H s, specify Cuba	lispanic Origin? (Sp an, Mexican, Puent	ecify Yes or No Rican, etc.)		American Indian, White, etc.
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Insperment of Health and Mental Hygiene. Insperments if item 27 is marked other then "neturel", or Items 23e or 28e-f show eny injury or other treumatic event, it e Madical Examinar must be notified at once.	by	1 X Never Married 2 Married 3	1 ∐Yes 2∭∑No If Yes, Give Year or Dates:		10	res 2∭X No	Specify:		Specify:	white
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filled Hygi sther	ပိ	17. Father's Name (First, Middle, Last)							. <i>Maide</i> n <i>Sumame)</i>	
ld be ental ked c	To Be	Bernard H. McGinn					Margaret	: Collir	ıs	
2 shoul and M is mari	-	19a. Informant's Name/Relationship (Type			•				er, City or Town, St	
and and realth ra 27		Bernard C. McGinn/	nephew		8 Cast1			onium,		
Pages 1 nent of H int: If ite		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ R	emoval from State	cen	ce of Disposition netery, cremator	ry or other plac	ce)	2 2005	20c. Location - C	ore, Maryland
it. Partment		<ul><li>4 □ Donation 5 □ Other (Specify)</li><li>21. Signature of Funeral Service License</li></ul>	10	new						
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/Medical		disease or condition resulting in death)	. Due to (or as a	conseque	ince of):	Colo				
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andin use	N/M	IF FEMALE: 23b. Was decedent pregnant 2	3c. If yes, outcome of 1□Live birth 2	f pregnand	cy leath 3□Eat	opic pregnancy	,		23d. Date	•
deati	slcla	in the past 12 months?	4 Pregnant at ti			ner (specify) _	y 		Month	n Day Year
The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	by Physician/Medical	9 Unknown						00 - Did		
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To the Hospitel or Attending Physicien: The law within 24 hours after death.  To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2.	edical (		sician: To the best of ner: On the basis of e and manner state	xaminatio						
Fo the vithin Fo the comple	Med	29b. Signature and title of certifier			A 1.	29c. Licens	e number	4.5	29d. Date signed (	Month, Day, Year)
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		30. Name and address of person who co	mpleted cause of de	alty (Item 2	23a) (Type, Prin	1) 0 +	7 1	1 0 0	11	14/20 74
10		13 Burnan	in y	٨)	8500 1	الإربي	hen 15	(vi) (	anny	e values y
Sta		31. Date filed (Month, Day, Year)	S 2005 Registra	s Signatu	re SX A	N. S. C.				
Registr	ar	IVIO V	1		P.					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** SARAH PINKARD 2005 0 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Town, or Location of Death Examiner Hospita th wes. andalls Nor town Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min.

8. Date of Birth (Month, Day, Year 4-13-19) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 230-12-5272 Yrs. Director 00 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If item 27 is marked other then "neturel; or items 23s or 28s-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other then "neturel", or itema 23a or 28a-f show treumatic event. Its Madical Exame and russ to calified at Baltimore Baltimore 1 ☐ Yes 2 ☐ No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7107 21207 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) Name (First, Middle, Maiden Sumame) Be Zata other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important: If it eny injury or o 1X Burial 2 Cremation 3 ☐Removal from State 4 □ Donation 5 □ Other (Specify) ConGreene Funeral Services berty Rd, Randallstown, MD 21133 23a. Part1. Eiter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final COROMBRY Pnysician DISERSE ARTERY disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner MARETES Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of) Physician/Medical Examiner To the Hospitel or Attending Physicien: The law requires that the death certificate be executed burial-transit VENCES P.O. Box 68760, WASTE STIMPL the IF FEMALE 23c. If yes, outcome of pregnancy
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1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 No 1 Yes director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 1 ☐ Yes 2 No Medical Certification: To 1 K Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Seath 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident after death. 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) mehla m.D 41410 2005.

Registrar
DHMH 17 Rev 1/2001

State

ENTER

C

32. Registrar's Signature

JOGINDER P

RAHDALLSTOWN MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HOSPITM

31. Date filed (Month, Day, Year)

MAY 1 6 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - Stata Registra Certificate of Death Reg. No. 1. Deceden('s Name (First, Middle, Last) 2. Date of Death 3. Time of Death 10 PM **Physician** 501 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner BALTIMUR 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) **Funeral** Year) Days Hours Months Min 1**X** M 2□ F 250-46-9762 73 Director 12-28-1931 South Carolina Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f ahow other traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Director **Baltimore** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? itams 23a USA 2707 Roslyn Avenue Funeral 21216 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 6 1 Yes 2 No Specify: þ 3 Widowed 4 Divorced "natural", Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filad within Department of Health and Mental Hygiene. Importent: If itam 27 Ia marked other than "any injury or other traumatic event, the Mesones. Elementary/Secondary (0-12) College (1-4or 5+) Painter Ship Yard 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hattie Allen Peterson ဂ္ Wallace Peterson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Theresa W. Brown/ Niece 2707 Roslyn Avenue Baltimore, MD 21216 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🛣 Burial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest Veteran 05-23-05 4 ☐ Donation 5 ☐ Other (Specify) Owings Mills, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral HOme 638 N. Gilmor St. Baltimore, MD 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 6 Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit Due to (or as a consequence of): Box 68760. Physician/Medicai the use as IF FEMALE 23c. If yes, outcome of pregnancy
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1 ☐ Yes 2 ☐ No certificate has page 2 autopsy 1 ☐ Yes 2 Division of Vital To the Hospital or Attanding Physician: 25. Was case referred to medical 26. Place of Death (Check only one examiner Hospital: Other: 2 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this funeral 27. Manner of Death Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending death. 1 Tes 2 No investigation Diractor: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
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State Registrar DHMH 17 Rev 1/2001 30. Name and address of person who

31. Date filed (Month, Day, Year)

ause of death (Item 23a) (Type, Print)

strar's Signature

32. Re

Physician Medical Examiner  Thomas William Pentz  Thomas William Pentz  As Pacility Name (If not institution, give street and number)  9642 Dundawan Road  S. Social Security Number 6 5. Sex  106-09-0997 12 M 2 F 88 Yrs.  S. Social Security Number 6 5. Sex  116-09-0997 12 M 2 F 88 Yrs.  S. Social Security Number 6 5. Sex  116-09-0997 12 M 2 F 88 Yrs.  S. Social Security Number 6 5. Sex  116-09-0997 12 M 2 F 88 Yrs.  S. Social Security Number 6 5. Sex  116-09-0997 12 M 2 F 88 Yrs.  S. Social Security Number 6 5. Sex  116-09-0997 12 M 2 F 88 Yrs.  S. Social Security Number 6 5. Sex  116-09-0997 12 M 2 F 88 Yrs.  S. Social Security Number 6 5. Sex  116-09-0997 12 M 2 F 88 Yrs.  S. Social Security Number 6 5. Sex  116-09-0997 12 M 2 F 88 Yrs.  S. Social Security Number 6 5. Sex  116-09-0997 12 M 2 F 88 Yrs.  S. Social Security Number 6 5. Sex  116-09-0997 12 M 2 F 88 Yrs.  S. Social Security Number 6 5. Sex  116-09-0997 12 M 2 F 88 Yrs.  S. Social Security Number 6 5. Sex  116-09-0997 12 M 2 F 88 Yrs.  S. Social Security Number 6 5. Sex  116-09-0997 12 M 2 F 88 Yrs.  S. Social Security Number 6 1. Sex North 6 1. Sex North 6 1. Security 7 M 2 F 88 Yrs.  S. Social Security Number 6 1. Sex North 6 1. Security Number 10 M 2 M 2 M 2 M 2 M 2 M 2 M 2 M 2 M 2 M		_	Amend Items/ 1 - State Registrar	<u> </u>	,		tificate o				Reg. No.	Ub	639
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17. Father's Name (First, Middle, Last)   18. Mother's Name (First, Middle, Malice) Summan)   17. Father's Name (First, Middle, Last)   19. Mailing Address (Street and Number of Paul Allock Number, Cryp Town, State 2. December of Paul Allock Number, Cryp Town, State 2. December of Paul Allock Number, Cryp Town, State 2. December of Paul Allock Number, Cryp Town, State 2. December of Paul Allock Number, Cryp Town, State 2. December of Paul Allock Number, Cryp Town, State 2. December of Paul Allock Number, Cryp Town, State 2. December of Paul Allock Number, Cryp Town, State 2. December of Paul Allock Number, Cryp Town, State 2. December of Paul Allock Number, Cryp Town, State 2. December of Paul Allock Number, Cryp Town, State 2. December of Paul Allock Number, Cryp Town, State 2. December of Paul Allock Number, Cryp Town, State 2. December of Paul Allock Number, Cryp Town, State 2. December of Paul Allock Number, Cryp Town, State 2. December of Paul Allock Number, Cryp Town, State 2. December of Paul Allock Number of	*				10c. City	. Town or Lo	cation						10d. Inside City Lim
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17. Father's Name (First, Middle, Last)   18. Mother's Name (First, Middle, Malicen Summan)   Cartrie   Mullelinix   Stanley   Pentz   19. Mailing Address (Street and Number of Pental Revealed Numbe	E BE	nera	11. Marital Status	12. Was Dec	edent Ever in U.S	3. 13.	Vas Decedent o	Hispanic Ori	igin? (Spe	ecify Yes or No	- 14. Rac		
17. Father's Name (First, Middle, Last)   18. Mother's Name (First, Middle, Malicen Summan)   Cartrie   Mullelinix   Stanley   Pentz   19. Mailing Address (Street and Number of Pental Revealed Numbe	i', or its	by Fu	, ,	d 1 ☑ Yes If Yes, Gi	2 □ No ve fulu T					rican, etc.)			
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21. Signature Sport all Sports (Specify)  21. Signature Sport all Sports (Specify)  22. Name and Address of Facility Schimunek Funeral Homes 9705 Belaix Rd., Baltimore, MD 21236  22. Name and Address of Facility Schimunek Funeral Homes 9705 Belaix Rd., Baltimore, MD 21236  23. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Intrinsia Biochor heart failure. List only one cause on each line.  AUID MOORDIAL INFACTION  Due to (or as a consequence or) AttHINGS INDITIC CARDIOVASULAR INISPASS:  Sequentially ist conditions, if any, leading to mimediate cause (final failure with any leading to death of the consequence or) AttHINGS INDITIC CARDIOVASULAR INISPASS:  Due to (or as a consequence or) AttHINGS INDITIC CARDIOVASULAR INISPASS:  Due to (or as a consequence or) AttHINGS INDITIC CARDIOVASULAR INISPASS:  Due to (or as a consequence or) AttHINGS INDITIC CARDIOVASULAR INISPASS:  Due to (or as a consequence or) AttHINGS INDITIC CARDIOVASULAR INISPASS:  Due to (or as a consequence or) AttHINGS INDITIC CARDIOVASULAR INISPASS:  Due to (or as a consequence or) AttHINGS INITIAL INIT	gien dr.	E O	Zionionaly/Socondaly (O 12)	2	1 40/ 5//	Fi	iesighte	r					
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21. Signature of or all general persons and persons of aculting Section (Specify)  22. Signature of or all general persons of the control of	if its	11.5		B □Removal from	Ctato C8	metery, crer	natory`or other p			1		-	
23a PATI. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.    Immediate Cause (Pinal Immediate Cause) (Pinal Immediat	tant: jury		//	_17 1/1	St.								
Throack or heart failure. List only one cause on each line.    Immediate Causer (Final disease or condition acausing on each line.)   Immediate Causer (Final disease or condition acausing on each)   Immediate Causer (Final disease or condition)	Depar Impor		21. Signature of Son ral Service L	oprise.									es
Immediate Cause (Final disease or condition resulting in dealth)   Due to (or as a consequence of)   THERCOLD ROTTIC CADIOVASOLIAR DISPASE			23a. Part1. Enter the disease, or o	omplications that	caused the death	Do not ent	er the mode of d	ing, such as	cardiac c	or respiratory a	rest,		Approximate Interval Between
The collect symmetric property of the control of the collection of	hvsician		Immediate Cause (Final			TAT. TNE	ARCTTON						Onset and Death
IFFEMALE: 23b. Was decedent pregnant in the past 12 months?			Cause (Disease or injury that initiated events	Due to	(or as a con u	ence of):	DÎAL CHRDIO	NEA A LUL	REA AR	NSON			1-2 HUR 7 10 YEH
24a. Was an autopsy finding prior to completion of death?  25. Was case referred to medical examiner?  1 Yes 2 No  26. Place of Death (Check only one)  27. Manner of Death  1 Natural 5 Pending investigation investigation 3 Suicide 4 Homicide 4 Homicide 5 Could not be determined 5 See Place of Injury 4 Home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number or	2		23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live l 4□Pregi	birth 2 ☐ Fetal nant at time of de	death 3□							,
The state of the	ned b	y P	Part II. Other significant condition	s contributing to d	leath but not resu	lting in the u	nderlying cause	iven in Part I		23e. Did to	bacco use contr	ibute to t	he cause of deeth?
25. Was case referred to medical examiner?    Types 2   No	n sign	d b	SYSTELIC H	YPERTEN	SION					1 🗆 1	es 210 No	3 ☐ Prob	oabły 4 □Unkno
25. Was case referred to medical examiner?    Types 2   No	s bee	piete	HOERLIPIDE	MA								Vere auto	psy findings availal
25. Was case referred to medical examiner?  1   Yes   2   No	te ha	E O	1/1-1							perfo	rmed?	leath?	
	tifica tor, p	a	25. Was case referred to medical					26. Place	of Death				2010
	is cel			Hospital: 1	Inpatient 2 E	R/Outpatien	t 3 DOA	thor				er (Specif	(v)
	ter th						28c. In						,,
	ath. r: Af ne fur	atio	2 ☐ Accident investiga	tion	, Day 1 day	,,			No				
	after de Diracto I in by th	ertific	datamai	ed 286. Place			eet, factory, offic	e	2	28f. Location (S City or Tow	Street and Numbern, State)	er or Rura	al Route Number,
	24 hours Funeral etely filler		(Check only 2 Medical E	caminer: On the b	asis of examinati	rledge, death on and/or inv	occurred at the restigation, in my	time, date an opinion, dea	id place, a	and due to the e	cause(s) and ma date and place, a	nner as s and due to	tated. the cause(s)
	ompli	Me		und man			29c. Lice	nse number			29d. Date signed	(Month,	Day, Year)
Staller and in the tone	> <b>⊢</b> 0		2 gladina.	( )	is AA		Don	1500	7				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	1//		30. Name and address of person w	no completed caus	se of death (Item	23a) (Tyne		.002	6		•	, ,	

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene [] [] 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** DELLA 4:10 0 2005 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Good Samaritan Hospital Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | September | 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** 1 □ M 2 🛛 F 180-03-1106 94 Yrs. 1910 Pennsylvania Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Item 27 is marked other than "natural", or Items 23s or 28s-1 show other traumatic event, the Medical Examiner must be notified at Maryland N/A Baltimore 1XXYes 2 □ No Director 10e. Street and Number 4403 Marx Avenue 10g. Citizen of What Country? 10f. Zip Code 21206 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Heelth and Mental Hygiene. snt: If Item 27 Ie marked other than "natural", or Ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🂢 No þ If Yes, Give Year or Dates: Specify: Specify: White 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown Rikteraltis ٥ Unknown Karpovich 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Darlene George/Daughter 3920 Marx Avenue Baltimore Maryland 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Importent: If Ite
eny injury or ot
gnce. 1X Burial 2 Cremation 3 Removal from State Parkwood Cemetery 5/13/05 Baltimore Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) Pame and Jodges of Faculty Levi and J. Buck. Inc. 5305 Hartord koad Baltimore Maryland 21214 21. Signature of Funeral Service Licensee Christina L. Hilton 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Death Immediate Cause (Final CIDOCIS **Physician** resulting in death) /Medical Due to (or as a consequence of): **Examiner** RENAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ISHEMIC The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical as the attending IF FEMALE use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No ŏ Day 4☐Pregnant at time of death 5 Other (specify) detached the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be 3 Probably 4 Donknown 1 ☐ Yes 2 ☐ No peeu 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed 1 Yes 2 No 2 No To the Hospitel or Attending Physician: filled in by the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 2 ER/Outpatient 3 DOA this 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Matural death. 1 Yes 2 No 2 Accident 24 hours after death Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 hor To the Fune completely fi one; and manner stated. 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 20060600 5007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BIVER NECK PANILAT KHETERPAN RS, BALTIMORE, MS -109 200532. Referrar's Signature State Registrar

			1 - For Registrar	State of Maryland / D		lealth and	Mental Hyg	•	16397
	Physici /Medio Examin	cal	Decedent's Name (First, Middle, Last)     OLIVE MAE I     4a. Facility Name (If not institution, give so GILCHRIST CENTER			or Location of Deat	2. Date of Dea Month May 10	Day Year	
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. last birt		If Under 24 Hrs Hours Min.	8. Date of Birth (Month, Day) Dec 10,	Year) 9. Bir	thplace (State or Foreign ountry) cryland
death with the Maryland	28e-f show	ector	10a. State 10b. County	e County	Phoenix  10f. Zip Code			Og. Citizen of What C	10d. Inside City Limits 1 ☐ Yes 2 No
th with	23a or	al Dir	3100 Sunset Lane			131		USA	ountry !
urs after dea	al', or items xaminer m	by Funeral Director	11. Marital Status  1 □ Never Married 2 ☒ Married  3 □ Widowed 4 □ Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	13. Was Decedent of If Yes, specify Cub  1 ☐ Yes 2 ☑ No	Hispanic Origin? (S an, Mexican, Puerl Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Whi Specify: [	
be filed within 72 hours after	Department of Health and Mental Hygiene. Importent: or Items 23a or 28e-f show Importent: If Item 27 is marked other then "natural; or Items 23a or 28e-f show any injury or other treumetic event, the Medical Examiner must be notified at once.	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 12th	cation 16a.  Completed)  College (1-4or 5+)	Decedent's Usual Occup (Give kind of work done life. DO NOT use retire Seamstress	pation during most of wo d)	rking	16b. Kind of Business Clothi Manufact	<b>n</b> g
should be filed	Mental Hyg arked other etic event,	To Be C	17. Father's Name (First, Middle, Last) Walter	Voshe11		18. Mother's Nar	ne (First, Middle, i	Maiden Sumame) Hart	
1 C, Mal	Health and Item 27 Is m other treum		19a. Informant's Name/Relationship (Ty, Russell Swartz 20a. Method of Disposition	(nephew) F	P.O. Box 392 Disposition (Name of ty, crematory or other plane)	, Phoeni	x, Maryl		
Dailling	tment of tent: If i		1 X Burial 2 ☐ Cremation 3 ☐ R '4 ☐ Donation 5 ☐ Other (Specify)	Woodla	awn Mem Pk	5/12	/2005	Easton, Ma	ryland
Dermit De	Departr Importe any inju		21. Signature of Funeral Service Liberis	10,000	Mitchell-	T7 1 C 1	d Funera	1 Home, In	C.
/	nysician Medical Kaminer		Martin D. Laws  23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	At Land Course on each line.  At Land Course on each line.  Due to (or as a consequence of	Sementra	ng, such as cardia	attinore correspiratory arr	est, Pary Latio	21212 Approximate Interval Between Onset and Death
te be executed		icai Examiner	Sequentially list conditions, and the cause. Enter Underlying cause. Disease or injury that initiated events resulting in death) Last	Due to [or as a consequence of					
the death certifica	been signed by the attending physician and should be detached for use as the buriat-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown V	Sc. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 □Ectopic pregnanc 5 □ Other (specify) _	у		23d. Date of de Month	livery Day Year
The law requires that the death	an signed by	þ	Part II. Other significant conditions cor	tributing to death but not resulting in	n the underlying cause gr	ven in Part I.	23e. Did tol	bacco use contribute t es 2 17 No 3 □ P	o the cause of death?
	ate has page 2	Completed					24a. Was a autops perform 1 🗆 Yes	sy prior to med? death?	utopsy findings available completion of cause of
ng Physicie	fter this	tion: To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Seath  1 No Natural 5 Pending 2 Accident investigation		Fime of 28c. Injury Wo	ner: 4 Nursing H	ath (Check only on lome 5 Reside 28d. Describe ho	- 5.4	ampuspiu
Lal or Atten	within 24 hours after death.  To the Funerel Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, fa building, etc. (Specify)	rm, street, factory, office		28f. Location (St City or Town	treet and Number or R n, State)	ural Route Number,
e Hospif	24 hour Funer etely fills	edical (		ician: To the best of my knowledge ler: On the basis of examination and and manner stated.					
To th	within To th compl	Me	29b. Signature and title of certifier	Com	29c kicen	P303		9d. Date signed (Monitory)	th, Day, Year)
	5		30. Name and address of person who co	mpleted cause of death (Item 23a)	Gype, Print)	7303 Kaltu	une we	hoere	
	Sta Registr		31. Date filed (Month, Day, Year)  MAY 1 6 2005	2. Registrar's Signature	beeks				

DHMH 17 Rev 1/2001

240 PM

5-10-05

PHILLIPS, OLIVE

			1 - For State of Marylar Registrar	_	artment rtificate			ind Me		giene Reg. No.	105	15398
	Physici	20	Decedent's Name (First, Middle, Last)						2. Date of Dea		Year	3. Time of Death
	/Medic	al :	4a. Facility Name (If not institution, give street and number)		4b. City, To		I section s		MAY	100	ounty of Deal	8.20 M
	Examin	er	NORTHWEST HOSPITAL CENTER				STOWN				LTIMOR	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs.		If Under 1		If Under 2		8. Date of Birt (Month, Da) NOV . 29			thplace (State or Foreign
	Director		213-14-8326	88 Yrs.					NOV.29	,1916		MD MD
	yland how			ty, Town or Lo	cation					-		10d. Inside City Limits
	Ba-f s	ector	MD BALTIMORE	BALT	IMORE							1 □ Yes 2 No
	with th	Funeral Director	10e. Street and Number  6 STONEHENGE CIRCLE #3		10f. Zip C	eboc	2120	າຂ		10g. Citize	n of What Co	ountry? USA
	death	nera	11 Marital Status 12. Was Decedent Ever in U	.S. 13.	Was Deceder	nt of His			cify Yes or No- lican, etc.)	. 14	Race - Ame	erican Indian,
9	s after , or Ite	by Fu	Armed Forces?  1 Never Married 2 Married 1 Yes 2 M No If Yes, Give  3 M Widowed 4 Divorced Year or Dates;	1	1 ☐ Yes 2		Specify:	, r dollo r	ilouri, etc.)		Black, Whit pecify:	WHITE
215-0036	2 hour	ted b	15. Decedent's Education	16a. Dece	dent's Usual	Occupa	tion			16b. Kind	of Business	Industry
212	ithin 7: ne. nem "n	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)		kind of work DO NOT use	done di retired)	uring most	of workin	g	OUN		
2	be filed within 72 hours after death with the Maryland Ital Hygiene. d other than "natural", or items 23a or 28a-f show event, I're Madreal Expired and a seent, I're Madreal Expired.		17. Father's Name (First, Middle, Last)	HOUS	EWIFE		18 Mothe	r's Name	(First, Middle,	OWN Maiden Si		
<u>a</u>	ed at a	To Be	SOL	НҮМА	N		_	INAH	(, , , , , , , , , , , , , , , , , , ,		aao,	SHUMAN
Maryland 27	s 1 and 2 should of Health and Men item 27 is marke other traumatic	-	19a. Informant's Name/Relationship (Type, Print)	1.1	-				Route Numbe	-		
	1 and Health Sm 27 ther tr		JEFFREY PLAINE / SON  20a. Method of Disposition 20b. I	3201 Place of Dispo			EY DR	RIVE	- BALT		, MD 2 ation - City or	
E P			1 X Burial 2 ☐ Cremation 3 ☐ Removal from State	ZUK AM	natory or oth	er place			140		LTIMOR	
altimore,	permit. Page Department of Important: If any injury of once.		21. Signature Funeral Service Licensee		and the second s				LEVINS			
20	88 58		Scott 1/2 Culler	8	900 RE	IST	<b>ERSTO</b>	WN R	<u> 0AD - 1</u>	PIKES		MD 21208
П			23a. Part1. Enter the disease, or complications that caused the deal shock, or heart failure. List only one cause on each line. Immediate Cause (Final									Approximate Interval Between Onset and Death
	rny <del>sicia</del> n /Medical		disease or condition resulting in death)  Due to (or as a consec		cropr	PAG	TAL	IM	THRU	,		
	Examiner		Sequentially set conditions b. Uni Carlot Ro		Hy	PER	TCH	SIDN				
	bed sit	nìne	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	uence of):	1							
<u> </u>	execuin and ial-trai	Examiner	that initiated events c c Due to (or as a consec	juence of):								
3/60	cate be executed obysician and the burial-transit	dical	d									
ğ ×	eath certific attending p for use as t		IF FEMALE: 23c, if yes, outcome of pregn	ancv						22	d Data of dal	in a
ROX	death certific e attending p d for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fete 1 Vac 2 FMb 4 Pregnant at time of c	el déath 3	Ectopic pred Other (spec					23	d. Date of del Month	Day Year
J.	at the de I by the a stached	Phys	9 □ Unknown / S□ Onknown									
ds,	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions contributing to death but not res	sulting in the u	nderlying cau	use give	n in Part I.			bacco use ′es 2□		o the cause of death?
Vital Records,	w requires been signer should be	Completed						_	24a. Was	an	24b. Were au	utopsy findings available completion of cause of
ž	9 4 9	omo							autop perfor	rmed? 2 No	prior to death?	
IIa	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?			101		of Death	(Check only o	/ 1		
ö	Phys this al di	To	27. Manner of Death 28a. Date of Injury	ER/Outpatier			4 🗆 Nui		e 5 🗌 Resid			cify)
0	nding Path. r: After e tuner.	ation	1 Natural 5 Pending (Month, Day Year) 2 Accident investigation	Injury	М	c. Injury Work	? 'es 2 □ N			, ,		
Division	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely tilled in by the funer	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At h	ome, farm, str fy)	reet, factory,	office		21	Bf. Location (5 City or Tow		Number or Ru	ural Route Number,
	ipital o		29a. Certifier 1TK Certifying Physician: To the best of my known		h occurred at	the time	e date and	d place at	nd due to the	Pauca/s) as	nd manner as	etatad
	To the Hospital or within 24 hours after or To the Funeral Dire completely tilled in E	edical	(Check only one) 2 Medical Examiner: On the basis of examina and manner stated.									
	To the within To the comp	Ž	29b. Signature and title of certifier				number		į.		signed (Monti	-
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11			30. Name and address of person who completed cause of death (Itel  NORTHWEST HOSPITML CEW		Print) 30		TOL		ATHIS M	211	32.	
5.0	Sta	_	31. Date filed (Month, Day, Year) 32. Pagistrar's Sign.			1000		7 7 7			<u></u>	
	Registr	ar	MAY 1 6 2005   Delice	5 A								

2005

PRANCIS ROTHE

State of Maryland / Department of Health and Mental Hygiene  Department of Health and Mental Hygiene  Land of Department of Health and Mental Hygiene  Department of Health and Mental Hygiene  May 12, 2005 May 12,					State							_	e.	
Document Name First Access, Lawy   March Lawy   L				1 - For State Registrer	Olate	or wary a				III WICITA		200		161.00
## Parties   Par					lle, Last)						e of Death	1 30 Sat Sat		3. Time of Death
## Separate Promotion Services and Control Services				Madeline Rems	en Rudd					Ma	iy 12,	2005	ear	8:10A M
Secure Secret Number   1.0 comp   2.0 comp   1.0 comp				4a. Facility Name (If not institution	on, give street and n	umber)		4b. City, Town,	or Location of	f Death		4c. County of	Death	
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Use at Testing State										Min. 8. Date	e of Birth nth, Day, Ye	ar) 9	. Birthpla Count	ace (State or Foreign ry)
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Secretary   Secr	036	ours a	þ	***	If Yes, G	ive **		1 ☐ Yes 2 🔀 No	Specify:			Specify:	Whi	te
Cartier Crane Remsen   Smille Gray Barnes   Smille Gray Barnes   Smille Gray Barnes   Smille Ba. Hale/Daughter   State Mailing Address (Sines and Anthres or Paris House Number or Paris House Numbe	5	72 h	etec	15. Decede (Specify only high	nt's Education est grade completed	()	(Give	kind of work done	during most	of working				•
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Cartier Crane Remsen   Smille Gray Barnes   Smille Gray Barnes   Smille Gray Barnes   Smille Ba. Hale/Daughter   State Mailing Address (Sines and Anthres or Paris House Number or Paris House Numbe	d 2	filed Hygie other		17. Father's Name (First, Middle	, Last)		Sect	ecary	18. Mother	r's Name (First,	Middle, Maid		iicai	CII
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23. Part I. Effer the disease, or complications that called the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.    Provided the death of the dea		and 2 salth and 27 li		Emilie B. Hale	/Daughter		7607	Laytonia	a Drive	e, Gaitl	hersbu	rg, Ma	ry1a	nd 20877
23. Part I. Effer the disease, or complications that called the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.    Provided the death of the dea	ore	ges 1 of He ff iten			3 □Removal from	20b.	Place of Dispo	sition (Name of matory or other pla	сө)	May 14,	20c	Location · Ci	y or Tow	vn, State
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23. Part I. Effer the disease, or complications that called the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.    Provided the death of the dea	Bal	Depar Mpor mpor any in		21. Signature of Funeral Service	Lice	1/0/	22 R	2. Name and Address ockville	ss of Facility Inc.	Robert 300 Wes	A. Pu st Mon	mphrey tgomer	Fun v Av	eral Home/
Thysician Modical Examiner  Th				23a, Part 1, Enter the disease, of	r complications that							805		
Congestive Heart Failure, Multiple Cancers   Status   S		Thursday.		shock, or heart failure. Lis	t only one cause on	each line.					,,			Interval Between
Sequentially list conditions.  Sequentially list indicated events.  Sequentially list indicated events.  Sequentially list conditions.  Sequentially list indicated events.  Sequentially li								Arrest						
State   Stat	П	Examiner		Conventingly list conditions				c Cardio	ascula	ar Disea	ase			
The part of the pa	-	ם וב	iner	if any, leading to infinediate cause. Enter Underlying	Due to	(or as a cone	quaries of):							
FEMALE: 23b. Was decedent pregnant time of death   2   Female   2		and and I-trans	xam	trial initiated events	C	Vor se a conce	aguanaa af\;							<del>-</del>
FFEMALE:   23c. If yes, outcome of pregnancy   1   Live birth   2   Felal death   3   Ectopic pregnancy   1   Live birth   2   Felal death   3   Ectopic pregnancy   1   Live birth   2   Felal death   3   Ectopic pregnancy   1   Live birth   2   Felal death   3   Ectopic pregnancy   1   Live birth   2   Felal death   3   Ectopic pregnancy   1   Live birth   2   Felal death   3   Ectopic pregnancy   1   Live birth   2   Felal death   3   Ectopic pregnancy   1   Live birth   2   Felal death   3   Ectopic pregnancy   1   Live birth   2   Felal death   3   Ectopic pregnancy   1   Live birth   2   Felal death   3   Ectopic pregnancy   1   Live birth   2   Felal death   3   Ectopic pregnancy   1   Live birth   2   Felal death   3   Ectopic pregnancy   1   Live birth   2   Felal death   3   Ectopic pregnancy   1   Live birth   2   Felal death   3   Ectopic pregnancy   1   Live birth   2   Felal death   3   Ectopic pregnancy   1   Live birth   2   Felal death   4   Pregnant at time of death   5   Chief (specify)   2   2   2   2   2   2   2   2   2	60,	be ey			. 500 10	(0) 43 4 001136	squerice or).							
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Address of person who completed cause of death (Item 23a) (Type, Print)  State    State   Stat				25. Was case referred to medic	al				26 Place			No 1	Yes 2	!□ No
The state of the course of the cause of person who completed cause of death (Item 23a) (Type, Print)  State    City or Town, State		S S S	<b>m</b>		Hospital:	Inpatient 2	☐ ER/Outpatier	nt 3 DOA Oth				6 □Other	(Specify)	
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The state of the course of the cause of person who completed cause of death (Item 23a) (Type, Print)  State    City or Town, State	sio	tendi leath. tor: A the fu	catl	2 Accident invest	igation not be				Yes 2□N					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  S. Rajan, M.D. 10810 Darnestown Road, #202, Gaithersburg, Maryland 20878  State  31. Date filed (Month, Day, Year)  MAY 16, 2005	Σ	or At after of Direct in by	artif	datan	nined 286. Plac	e of Injury - At ding, etc. (Spec	home, farm, str cify)	eet, factory, office		28f. Loca City	ation (Street or Town, St	and Number ( ate)	or Rural i	Route Number,
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  S. Rajan, M.D. 10810 Darnestown Road, #202, Gaithersburg, Maryland 20878  State  31. Date filed (Month, Day, Year)  MAY 16, 2005	Bustill	spitel ours nerel filled		29a. Certifier 1X Certify	ng Physician: To th	ne best of my kr	lowledge deat	n occurred at the ti	me date and	I place, and due	to the cause	o(s) and mann	er as stat	ted.
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  S. Rajan, M.D. 10810 Darnestown Road, #202, Gaithersburg, Maryland 20878  State  31. Date filed (Month, Day, Year)  MAY 16, 2005		24 h	dic	Check only 2 Medica	Exeminer: On the	basis of examin	nation and/or in	vestigation, in my	pinion, death	h occurred at the	e time, date a	and place, and	due to t	he cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  S. Rajan, M.D. 10810 Darnestown Road, #202, Gaithersburg, Maryland 20878  State  31. Date filed (Month, Day, Year)  MAY 16, 2005		To the vithing To the comp	ž	29b. Signature and title of certifi	er 101 MAG	u da.		29c. Licens	e number		29d.	Date signed (M	Aonth, Di	ay, Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  S. Rajan, M.D. 10810 Darnestown Road, #202, Gaithersburg, Maryland 20878  State  31. Date filed (Month, Day, Year)  WAY 16, 2005  3 Registrar's Signature				D K. JW	yuvou	NOON	1	D533	67		May	13, 2	005	
State 31. Date filed (Month, Day, Year) 37. Registrar's Signature		6												
Registrar MAY I 6 2005 Especial III		3		S. Rajan, M.I.	10810	Darnest	own Ro	ad, #202,	Gaith	hersburg	g, Mar	y1and	208	78
			1	MAYI	6 2005	mus s	U 199	140						

sicia ledic		Decedent's Name (First, Middle, Las     CATHERINE ROHN	Catherine Mar	y Rohn	1	Death	2. Date of Death Month MAY 6	Pay 2005	3. Time of Death 1:15 PM
amin		4a. Facility Name (If not institution, give	15		Timo	Location of Death		4c. County of De	math we
eral tor		5. Social Security Number 6. Security Number 1 1 215-07-7362 Usual Residence of Decedent	7. Age (In yrs. I	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea Apr 7, 1	ar) (	irthplace (State or Foreig Country) aryland
IN DAIL	tōr	10a. State 10b. County  Maryland Baltimor		y, Town or Lo	cation Lmonium				10d. Inside City Limit:
100 80	Director	10e. Street and Number 2300 Dulaney Val			10f. Zip Code	1093	10g.	Citizen of What (	•
event, ing medical Examiner man be colling at	by Funeral	11. Marital Status  1 X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.: Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba		pecify Yes or No- p Rican, etc.)	14. Race - An Black, Wh	nerican Indian, nite, etc.
is western	Completed	15. Decedent's Elementary/Secondary (0-12)		(Give	dent's Usual Occup kind of work done o DO NOT use retired CCRETARY	during most of world	sing 16b.	Kind of Busines	
Citize treatment event,	To Be Co	12th 17. Father's Name (First, Middle, Last) John Henry Rohi	n		cretary		e (First, Middle, Maid Emma Kelly		Store
	-	19a. Informant's Name/Relationship (7		Virte-120200000		and Number or Ru	ral Route Number, Cit	y or Town, State	
		20a. Method of Disposition 1	20b. Pl	ынысыгу, сты	natory or other plac	B)	White Hall Date 20c. L3/2005 Ba		
once.		21. Signature of Funeral Service Cooperation D. Laws	Jawson	22 N	2. Name and Addres	ss of Facility Viedefeld	Funeral F Itimore, N	Home In	C -
ian cal		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Sinvat	ri. Do not ent	er the mode of dyin	g, such as cardiac	or respiratory arrest,	Tarita	Approximate Interval Between Onset and Death
er	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence.  Due to (or as a consequence.  Due to (or as a consequence.	lence of):	tery	Dise	we		yeins.
	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnal 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	Ectopic pregnancy Other (specify)			23d. Date of d Month	elivery Day Year
	ğ	Part II. Other significant conditions co	ntributing to death but not resu	ulting in the u	nderlying cause give	n in Part I.	23e. Did tobacci		to the cause of death?  Probably 4 □Unknown
	Completed						24a. Was an autopsy performed?	prior to death?	
Ì	Certification; To Be	25. Was case referred to medical examiner?  1	Hospital: 1 ☐ Inpatient 2 ☐ I 28a. Date of Injury (Month, Day Year)  28e. Place of Injury - At hobuilding, etc. (Specify	ER/Outpatien 28b. Time of Injury	28c. Injury Work	or: 4⊠ Nursing Ho	h (Check only one)  me 5 Residence 28d. Describe how in  28f. Location (Street. City or Town, Ste	jury occurred and Number or F	
		(Check only 2 Medical Exam	sician: To the best of my knowner: On the basis of examinati	wledge, death	occurred at the tim	e, date and place,	and due to the cause	(s) and manner a	as stated.
	Medical	29b. Signature and title of certifier	and manner stated.	M	29c. License			Date signed (Mor	
1		30. Name and address of person who c	ompleted cause of death (Item	23a) (Type,	Print)		1.0		

ROHM, CATHERINE

State of Maryland / Department of Health and Mental Hygiene 2 0 5 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 10, 2005 4:33 PM MAY ROSEMAN RHEA /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner BALTIMORE SPRINGHOUSE PIKESVILLE If Under 1 Year | If Under 24 Hrs. Birthplace (Stete or Foreign Country) 8. Date of Birth (Month, Day, Year) NOV. 9, 1920 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1□M XXF 84 Director 215-16-1576 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ite Machall Event 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2√No BALTIMORE PIKESVILLE Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8911 REISTERSTOWN ROAD, #230 21208 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ☐Yes 2 🗓 📉 1 □ Never Married 2 □ Married 1 ☐ Yes XX No Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates: Specify: ð Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be SAPPERSTEIN KATIE UNOBTAINABLE **JACOB** 20 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7690 BELAIR ROAD; BALTIMORE, MD 21236 HARVEY LEVIN/ATTORNEY 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) MIKRO-KODESH-BETH ISRAEL 5/13/2005 BALTIMORE, MD 22. Name and Address of Facility
SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final disease or condition 105 clerosis **Physician** 20 Years disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 the attending physician hed for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) detached 9 Unknown signed by Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ withu lower extremition 1cers 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy page 1 ☐ Yes 20 To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 28b. Time of 5 🗋 Pending 1 Natural Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title D0020964 May 11. 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8630 Liberty Plaza Mall Randallstown, MD Ginsberg, M.D. Jerome H. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

MAY 1

ORIGINAL

.05-3333 B.K.S Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. TERRANCE E. SMITH State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Oate of Death Day **Physician** Year errance DMITT MAY 2005 0315 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5000 BLOCK NORWOOD AVENUE BALTIMORE CITY 8. Oate of Birth (Month, Day, Year 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Months Oays Hours 419-21-1904 1 M 2□F Yrs. Director Usual Residence of Decedent the Maryland 10a State 10c, City, Town or Location 10h County 10d. Inside City Limits 28a-f shov 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinar must be notified at Bal MD 1 Yes 2 No Director timore more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5a07 21207 by Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. permit Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Inportant: If them 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Exatinat once. Never Married 2☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) room 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be raia Omi bria elations is the Prior Smith 19b. Mailing Address (Street and Number or Rural Rou e Number, City or 5207 Boswor othe ito. 20a. Method of Disposition
1 □ Burial 2 ★Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State 4 Donation 5 Other (Specify) 21. ign ture o Funeral Serv Services Road 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Junshot Wounds 2) 0+ /Medical Due to (or as a consequence of). **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): ed by the attending physicien and detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Oate of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 

Yes 2 □ No 24a. Was an autopsy performed? Yes 2 \( \square\) No 1X Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) AT SCENE Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 XYes 2 ☐ No 28a. Date of Injury
(Month, Day Year)
TOUK 5 14 05 28b. Time of Injury AM 3:06 AM 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural death. Subjec 2 Accident 6 ☐ Could not be 3 🔲 Suicide 28e. Place o Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 5000 13 LK., determined 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di ca BaltimoreMD Norwood tre. 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier

State Registrar

29b. Signature and title of certifier

6

DHMH 17 Rev 1/2001

29c. License number

OCME

of death (Nem 23a) (Type, Print) 111 Penn Street Baltimore, Maryland 21201

29d. Date signed (Month, Day, Year)

MAY

14, 2005

			1 - For State Registrar	State of	Marylar		artment				ental Hy	_	200	5 17	"   0
			Decedent's Name (First, Mid	Idle, Last)				-			2. Date of De			3. Time	of Death
	Physici /Medi		Matthew Stat	on Jr.							April	$30^{Da}$	2005 <sup>Year</sup>	1:58	
	Examir		4a. Facility Name (If not instituti	ion, give street and num	ber)		4b. City, 7	Town, or	Location o	of Death			County of Dea		
			7205 Windsor M				Wood	dlaw	n			Ва	ltimore	Count	У
	Funeral		5. Social Security Number	6. Sex 1 2 M 2 ☐ F	. Age (In yrs.		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	ay Year)	9. Bi	rthplace (State	or Foreign
	Director		212-20-6539 Usual Residence of Decedent	16-11-261		52 Yrs.					8-24	-52	MD		
	show		10a. State 10b. Coun	ty	10c. Cit	y, Town or Lo	cation							10d. Inside	City Limits
	Man,	ţ	MD Balt	imore	Wi	ndsor	Mill	Ĺ						1 ☐ Ye	s 2 No
	th the or 28,	ie	10e. Street and Number				10f. Zip					10g. Cit	izen of What C	ountry?	
	23a c	by Funeral Director	3129 Cambrid	ge Dr.			212	244				USA			
	r dea tems	nei	11. Marital Status	12. Was Deced Armed Ford 1Yes 2	lent Ever in U ces?	.S. 13.	Was Decede	ent of Hi	spanic Ori	gin? (Spe	cify Yes or No Rican, etc.)	)-	14. Race - Am Black, Whi		
36	s afte	y F	1 X Never Married 2 Ma 3 Widowed 4 Divorce	If Yes, Give			1 □ Yes 2		Specify:		, ,		Specify: B	•	
21215-0036	ture!	ed b		ed Year or Da	les:	16a Decer	dent's Usual	I Occupa	tion			16h K			
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2	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "neturel", or Items 23a or 28a-1 show eumatic event, the Medical Exsourer must be mutified at	Be C	17. Father's Name (First, Middle	e, Last)					18. Mothe	r's Name	(First, Middle,	Maiden	Sumame)		
<u>a</u>	Menta Menta arked arked	70	Matthew Stat	on Sr.					Sere	na l	Jpton				
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Maryla to of Health and Mental Hyglene. If itiem 27 is marked other than "neturel", or Items 23a or 28a -f show or other treumetic event, II a Medical Exeminetr wat be notified at		19a. Informant's Name/Relation	, , , , ,									r Town, State, .		
	1 and 2 Health iem 27		Mildred Wils	on (mothe							-		1 MD 2		
Baltimore,	permit. Pages 1 and Department of Health Importent: If item 27 any injury or other tr once.		20a. Method of Disposition 1 ☐Burial 2 ☐ Cremation		iato	lace of Dispo emetery, cren			)		ate		cation - City or		
Ē	permit. Pages Department of Importent: If it any injury or o		' 4 □ Donation 5 □ Other (		Sac	cred I			1 = ::::				dalk,		
Ba	permit. Departn Importe any inju		11/01/01	e Licensee									s Jr. Md 212		
		-	23a. Part 1. Enter the disease	or complications that ca	sed the death								Ma ZIZ	Approxima	nte
No.	Enysician		23a. Part 1. Enter the disease shock, or heart failure Lis Immediate Cause (Final	st only one cause on a	ch line.				,		,			Interval Be Onset and	tween
	/Medical		disease or condition resulting in death)	a. Due to (o	r as a consequ	uence of):	con								
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687	ficate phys s the	edical		d											
Вох	eath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco								,	3d. Date of del	iven	
Ö.	death e atte	icia	in the past 12 months?	4 ☐ Pregna	th 2 Fetal		Ectopic pre Other <i>(spe</i>						Month		Year
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ord	w require been si should b	ted									1 🗆 Y	es 💆	No 3□Pr	obabły 4 🗌	Unknown
Vital Records,	law ras be	Completed									24a. Was autop		24b. Were au	Itopsy findings	available
<u>=</u>		Con									perfor	rmed? 2 ☐ No	death? Yes		2030 01
Vita	ician: certific	Be	25. Was case referred to medic examiner?							of Death	Check only o	ne)			
of	Phys this	٦.	1X Yes 2 No 27. Manner of Death			ER/Outpatient		-	4 🔲 IVUI				XXOther (Spec	cify) at s	scene
	ding h. After funer	ertification:	1 □Natural 5 □ Pend	ing 28a. Date of (Month, tigation	Day Year)	28b. Time of Injury		Work?			d. Describe h		SM	114 Kg	ca=Llie
Division	or Attending after death. Director: After in by the fune	fica	3 ☐ Suicide 6 ☐ Could	l not be	Injury - At ho				2 2 1	-			Number or Ru		
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	To the Hospitel or within 24 hours after to the Funerel Discompletely filled in	alc	29a. Certifier 1☐ Certify	ing Physician: To the b	est of my know	wledge, death	occurred at	the time	, date and	Inlace an	d due to the o	alleo/e)	and mannor as	stated	
	the He hin 24 the Fu	edical	(Check only one)	I Examiner: On the bas and manne	is of examinat	ion and/or inv	estigation, in	n my opi	nion, death	n occurred	d at the time, o	date and	place, and due	to the cause(s	s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifi	er A				License			2		signed (Month		
,			Moughte	I he you	le t	W		.C.M	. L.			Apri	il 30,	2005	
	,		30. Name and address of person	who completed cause	of death (Item	23a) (Type, F	Print)	on C	troot	Po	ltimos	) M.	aryland	21.20	1
			31. Date filed (Month, Day, Year	N. KUR	istrar's Signar		TT 1 CI	3	rreet	, Dd	TUTHOL	=, Ma	ar y rand	2120	L
	Sta Registr	-	MAY 1	6 2005	istrar's Signat	& A	no of								

		1 - For State Registrar	State of Maryla		artment of F			jiene	75 1010
Physic /Med	ical	1. Decedent's Name (First, Middle, Last)		50/es	<del>-</del>		2. Date of Dea Month	9020	
Exam		4a. Fecility Name (If not institution, give s  Genesis Health Ca  5. Social Security Number 6. Sex	re	rs. last birthday)	If Under 1 Year	llers ví	lle	9	ne Arundel  Birtholace (State or Foreign
Director		219-58-3522  Usuel Residence of Decedent  10a. State 10b. County	M 2□F 54	Yrs.	Months Days	Hours M	NOV. 27	, 1950	Maryland  10d. Inside City Limits
death with the Maryland me 23a or 28a-f ehow	Director	Maryland N/A  10e. Street and Number	100.	City, Town or LC	Baltime 10f. Zip Code	ore		l 0g. Citizen of Wh	1 X Yes 2 □ No
after or Its	by Funeral D	3691 Kenyon Avenu  11. Marital Status  1 X Never Married 2 Married 3 Widowed 4 Divorced	C.  12. Was Decedent Ever in Armed Forces?  1 ☐ Yes 2 Ø No If Yes, Give Year or Dates:		Was Decedent of Hiff Yes, specify Cubin	21213 Hispanic Origin? an, Mexican, Pu Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race -	S. A. American Indian, White, etc.  White
Z I Z I 3-UU30 ed within 72 hours af ygiene "natural", or tr. tre Medical Exam	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12th Grade	cation e completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired Park Main	during most of v tenance			ness/Industry
TYIZILU hould be file d Mental Hy marked oth	To Be	17. Father's Name (First, Middle, Last)  Shandon L. Soles,  19a. Informant's Name/Relationship (Ty)		19h Maifi	ng Address (Street	Ida	Name (First, Middle, C. Davis Rural Route Number		ate Zin Code)
Baltimore, Mai permit. Peges 1 and 2 st Department of Health and Importent: If Item 27 is n any injury or other traun		Cheryl Lesage (Cou  20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ R  4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Fuperal Service License	emoval from State   1	274 No. Place of Dispo cometery, cres ULANCY Memorical	Nathan Wa psition (Name of Tatory or other pla Vacable Gardens 2. Name and Addre	Mill  5/1  ess of Facility S	ersville,	Maryland 20c. Location - Ci Timonium Funeral H	d 21108 ty or Town, State Maryland Homes
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death certific attending perior use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	3c. If yes, outcome of pre 1  Live birth 2 F 4 Pregnant at time of	etal death 3	Ectopic pregnanc	у		23d. Date of Month	
ecords, P.O. law requires that the de as been signed by the 2 should be detached	þ	Part II. Other significant conditions con	tributing to death but not	resulting in the u	nderlying cause giv	ven in Part I.			ute to the cause of death?
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VISION OF VIKAL F Attending Physician: The rideath. ector: After this certificate by the funeral director, pag	ation: To Be	25. Was case referred to medical examiner?  1  Yes 2 No  1 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	lospitaf: 1 ☐ Inpatient 2 28a. Date of Injury (Month, Day Year	2 ER/Outpatier 28b. Time o	f 28c. Injui Woo	ner: 42 Nursin	Death (Check only or g Home 5 ☐ Reside 28d. Describe ho		(Specify)
i Sign	i Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Sp.	ecify)			City or Town	n, State)	or Rural Route Number,
To the Hospitel within 24 hours a To the Funerel to completely filled	Medical	29a. Certifier (Check only one) 2 Medical Examination)  29b. Signature and title of certifier	sician: To the best of my ner: On the basis of exam and manner stated.	knowledge, deat nination and/or in	vestigation, in my c	opinion, death or	ccurred at the time, d	ause(s) and mann late and place, and 19d. Date signed (i	d due to the cause(s)
128		30. Name and address of person who co	mpleted cause of death (	Item 23a) (Type,		775- LRCH	3	5/11	1
S Regis		21 Date filed (Month Day Year)	32. Registrar's Si	ionature			۷ ۲ ۷ د ع		-/

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year Antonio Sangalana 9:26 PM Mau 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death North Arundel Hospital GLEN BURNIE ANNE ARUNDEL 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months 1**X**M 2□ F Director Yrs 586.60.0867 84 JAN 17, 1921 PHILIPPINES Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, I'm Medical Evaninal must be notified at anone. 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director MD ANNE ARUNDEL GLEN BURNIE 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 1225 CRAWFORD DR GLEN BURNIE 21061 Funera USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married XX Married Y Yes 2 No It Yes, Give Year or Dates: 45–68 Baltimore, Maryland 21215-0036 2 No Specify: à 3 ☐ Widowed 4 ☐ Divorced Specify: XX FILIPINO Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 STEWARD U.S. NAVY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 LIBERATO SANGALANG SEVERINA TUAZON 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ESPERANZA SANGALANG WIFE 1225 CRAWFORD DR GLEN BURNIE, MD 21061 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State MD VET CEM CROWNSVILLE 5.16.2005 CROWNSVILE, MD 22. Name and Address of Facility
FINK FUNERAL HOME, P.A. GREGORY FINK M01148 426 CRAIN HWY SW GLEN BURNIE, MD 21061 23a. Part Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Gause (Final disease or condition resulting in death) **Physician** Chronic Obstructive Disease Ulmonam /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medical Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. phys IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de. 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 🗆 No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ▼No certificate has autopsy performed 1 ☐ Yes 2 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 ☐ Yes 2 X No ihis 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending after death. investigation М 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

31. Date filed (Month, Day, Year)

aluand

32. Registrar's Signature

M.D.

2005

16 (201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SCO HUSPITAL DR GLEN BURNIE MD 2100 D0060721

2005

			1- For State of Maryland Registrer		artment rtificate			and M		iene	115	1010
	0		Decedent's Name (First, Middle, Last)						2. Date of Deat		UU	3. Time of Death
	Physic /Medi		Harry R. Smith Jr.						Month May 13,	Day 2005	Year	2:15 A M
	Exami		4a. Facility Name (If not institution, give street and number)		4b. City, To	own, or	Location of	f Death	11ay 13,	4c. Count	of Death	2:15 A
			Collington Episcopal Life Center	r			lvill					eorges
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. las		If Under 1	Year	If Under 2	24 Hrs.	8. Date of Birth	1 1111		
	Director		577-22-4605 XDM 2DF 78	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day, June 26	Year) 1926	Mary	lace (State or Foreign stry) y Land
	pc ,		Usual Residence of Decedent									/ Laria
	within 72 hours after death with the Maryland ene. than "neturet", or Items 23e or 28e-f show the Madical Examinet must be notified at	<u>_</u>	10a. State   10b. County   10c. City, 1   MD   Prince Georges   Mitc		cation ville						1	Od. Inside City Limits
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	or 2	Die	10e. Street and Number		10f. Zip C	ode			10	g. Citizen of	What Coun	itry?
	ath w	<u>a</u>	10450 Lottsford Road #4117		207	21				USA		
	tems	ne	11. Marital Status 12. Was Decedent Ever in U.S. Amed Forces?	13.	Was Deceder	nt of His	spanic Orig	in? (Sp	ecify Yes or No- Rican, etc.)		e - Americ	
36	or l	by F	1 Never Married 2 Married Y Yes 2 No		I□Yes 2		Specify:			Specif	T 71 .	
8	hour urel	d b	3 Widowed 4 Divorced Year or Dates: 144-14	16						Specii	y. 11111	
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Baltimore,	permit. Pages 1 an Department of Heal Importent: If item 2 any injury or other once.		21. Signature of Funeral Service Licensee	22	. Name and A	Address	of Facility	Rob	ert E. E	vans F	unera	1 Home
	407.00		1272		10000 7	Anna	iboT18	s Ko	ad Bowle	, MD	20715	
П			23a. Part1. Enter the disease, or complications that caused the death. [shock, or heart failure. List only one cause on each line.						1	st,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Mo	60	1/	•	113	aterio			Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequent	ce of):				7				f.cc.
	xaiiiiioi	<u>.</u>	Sequentially list conditions, b.									
	be tis	Examiner	Sequentially list conditions, if any, leading to immediate gause. Enter Underlying	ce of):								
	and -tran	кап	Cause (Disease or injury that initiated events resulting in death) Last									
8760,	cate be executed physician and the burial-transit		Due to (or as a consequent	ce or):								
87	cate physi the t	dlcal	d									
9 ×	n certifii anding p use as		IF FEMALE:			-					1	
Вох	eath certifi attending for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dealers.	ath 3 🗌	Ectopic pregr					23d. Dat	e of deliver	,
o	the shed	yslo	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 ☐ Unknown	າ 5∐	Other (special	fy)				10101	iui c	Day Year
P.O.	that the death led by the atter detached for u	P	Part II. Other significant conditions contributing to death but not resultin	- 1- 4								
Vital Records,	og pe	by	Tartin. Other significant continuous contributing to death but not resultin	g in the un	derlying caus	se given	in Part I.					cause of death?
0	w requir been si should	etec	116/00/00	9 0 100				_	1 Tes	2 <b>(</b> No	3∐ Proba	bly 4 □Unknown
ec	has b	Completed			_				24a. Was an autopsy	24b. V	Vere autop	sy findings available pletion of cause of
		Cor							performe	d? d	eath?	Plotton of Salase of
/ita	icien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?			2	26. Place o	f Death	(Check only one)			
		၉		Outpatient	3□ DOA	Other:	Nurs	ing Hon	ne 5 🗆 Residen	ce 6 Othe	or (Specify)	
Division of	Attending Physicien: It death, sector: After this certification in the funeral director, It	on:	27. Manner of Death  1 ☐ Matural 5 ☐ Pending  28a. Date of Injury (Month, Day Year)  28b.	o. Time of Injury	28c.	Injury a Work?			8d. Describe how			
<u>sio</u>	tend leath tor: / the f	catl	2 Accident investigation		М		s 2 No	0				
<u>≥</u>	after death Director: in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)	, farm, stre	et, factory, of	fice		2	8f. Location (Stre City or Town,	et and Numbe	or or Rural i	Route Number,
	urs a									,		3
	Hosp 4 hou Fune Fune	edical	29a. Certifier   Check only one)   Check one)   Check only one)   Check one)   Check one)   Check one)   Check one)   Check one)   Check o	dge, death and/or inve	occurred at the	he time,	date and	place, a	nd due to the cau	se(s) and mar	ner as stat	ted.
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Med	and mainlet stated.									
	T With		29b. Signature and title of certifier			cense n		9	29d	. Date signed	(Month, Da	ay, Year)
	- A		real fee				107	(	L	1(3)		
	1011		30. Name and address of person who completed cause of death (Item 23:		rint)	. \.	V	D .	/ ~	1	mi	20706
		-	20. 14. 600 costa 0 1.0 1	to t	Free	-wet	~ ~ ~	7 6 2		14-61-4	١ / ٠٠٠	
: 0	Sta		31. Date filed (Month, Day, Year)  32. Registrar's Signature	1								
370	. Registr	al .	MAY 1 6 2005 Page 8	A Second	2							

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Maryla		artmen rtificate			nd Mental F	lygien Reg. N	2000	16408
	Physic	ian	1. Decedent's Name (First, Middle, Las						2. Date of Month	Death		3. Time of Death
	/Medi		Susie D. Ski						May	15,	2005	7:30A M
4	Exami	ner	4a. Facility Name (If not institution, give					Location of I	Death	4	c. County of Death	
-			2302 Sandymous 5. Social Security Number 6. Se		o foot high deal	F :		burg If Under 24	I Hro		Carrol1	
	Funeral Director			7. Age (in yr.	s. last birthday) Yrs.	Months	Days		Hrs. 8. Date of (Month, Jan.	Birth Day Yea	9. Birth	nplace (State or Foreign untry)
			Usual Residence of Decedent	00	,				uaii.	11,	1949 Ma	rýland
	irylan show	_	10a. State 10b. County	10c. 0	City, Town or Lo	cation						10d. Inside City Limits
	Ba-f s	cto	MD Carrol	1	Sykesv	ille						1 ☐ Yes 🏋 💢 No
	vith th	Dire	10e. Street and Number			10f. Zip	Code			10g. C	itizen of What Cou	intry?
	s 23g	ra	3800 Sykesvi					784			U.S.A.	
	item item iner	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes ※ No	U.S. 13. V	Vas Deced Yes, spec	ent of His ify Cuban,	panic Origin , Mexican, F	n? (Specify Yes or Juerto Rican, etc.)	No-	<ol> <li>Race - Amer Black, White</li> </ol>	
980	urs el	by	3 ☐ Widowed X Divorced	If Yes, Give Year or Dates:	1	☐ Yes X	X No	Specify:			Specify:	White
9	be filed within 72 hours efter death with the Maryland hat Hyglene. d other than "naturel", or items 23a or 28a-f show event, it's M-dical Examinar must be notified at	Completed	15. Decedent's Edu	cation	16a. Deced	ent's Usua	l Occupati	ion		16b. I	Kind of Business/I	
2	within 7	npie	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	NOT us	k done du e retired)	ring most of	f working			,
7		S	12		Re	cept	ioni	st			Medica	l Care
and	should be filed nd Mental Hygi marked other matic event, I	Be	17. Father's Name (First, Middle, Last)				1	8. Mother's	Name (First, Mida	lle, Maide	n Sumame)	
3	should the	2	William F. Sk	A A					y Carey			
Maryland 21215-0036	2 m m m		19a. Informant's Name/Relationship (T)						or Rural Route Num			
	Health Health tem 27 other tr		Mary Pierce / I		Place of Dispos	sition (Nam	e of		Rd. Fink		rg, MD ocation - City or T	
Baltimore,	permit. Pages Department of H Importent: If ite any injury or ot		XX Burial 2 ☐ Cremation 3 ☐ F '4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State	<ul> <li>Plea</li> </ul>	atory`or oti	her place)	n   5 /				
∄	artme orter injur		21. Signature — unaral Searce Licens								mber, M	apel P.A.
ä	Depa impo any ir		1 Charl	Jun	_ 11	605 1	Reis	ters	town Rd.	Owi	nas Mill	ls, MD2111
8760,	Physician bhysician and physician and physic	dicai Examiner	23a. Part1. Enter the disease, or complished, or heart failure. List only or immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death) Last	Due to (or as a conse	quence of):	ymr	pho	Ha				Interval Between Onset and Death
P.O. Box 68	I the death certif by the attending ached for use as	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pregn 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 6 9 □ Unknown	aldeath 3∐6	Ectopic pre Other (s <i>pe</i>					23d. Date of delive	ery Day Year
Records, F	w requires tha been signed should be der		Part II. Other significant conditions cor	tributing to death but not re-	sulting in the und	derlying cau	use given	in Part I.		tobacco	_	ne cause of death?
		Completed					-		perl	s an opsy formed? 2 4 No	prior to con death?	psy findings available mpletion of cause of 2 No
Viital	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	ospital:					Death (Check only			2
Division of	Jing Ph Jing Ph After th funeral	Certification; To	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	3 DOA 280 M	c. Injury at Work?		ng Home 5 ☐ Res 28d. Describe		6 Dther (Specify occurred	Hanking 1
<u>X</u>			3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	(y)				City or To	own, State	,	
	To the Hospital or within 24 hours afte To the Funerel Dir completely filled in	Medical	one)	ician: To the best of my kno er: On the basis of examina and manner stated.	owledge, death outline and/or inve	stigation, ir	n my opini	on, death o	ace, and due to the courred at the time	, date and	place, and due to	the cause(s)
	8 <b>2</b> Ki 2		29b. Signature and title of certifier	N. n.	111	29c. I	License nu	umber	0	29d. Dat	te signed (Month, I	Day, Year)
/	· ~	-	rema	rull	100		$\sim$	20	2	C_	-10-0	5
5	1		Flaviorhruter m	pleted cause of death (Item D 555 Solu	th Co	rint)	Stre	ict 1	Wasthi	usta	L MD	21157
	Sta Registra		MAY 1 6 2005	32. Registrar's Signa	Aporti.	D.						

			State of Maryland	d / Depa		lealth and I	Mental Hygi	_	15 16409
Physic /Med	lical	1. Decedent's Name (First, Middle, Last) Robert Lee Seitz			Ab City Town	ad anation of Dooth			
Exami Funera Director		4a. Facility Name (If not institution, give sind Hospice of Baltimo S. Social Security Number 6. Sax 218-26-2910	re Gilchrist		•	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Feb. 14,	Baltime	
P .		Usual Residence of Decedent  10a. State 10b. County  MD Baltimore	10c. City Tows	, Town or Lo	cation				10d. Inside City Limits 1 ☐ Yes 2 🛣 No
th with the 23e or 28	Funeral Director	10e. Street and Number 1406 Midmeadow Roa	d		10f. Zip Code 21286			og. Citizen of Wh	iat Country?
nours after dea	þ	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	<ol> <li>Was Decedent Ever in U.S Amed Forces?</li> <li>Myes 2 ☐ No If Yes, Give Year or Dates:</li> </ol>		Vas Decedent of H Yes, specify Cuba □ Yes 2 No	lispanic Origin? (Si an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)		- American Indian, White, etc. White
in 72 h	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	16a. Deced (Give life. L Superv		ation during most of wor d)	king S	6b. Kind of Busi ocial Se dministr	ecurity
aryically 212 should be filed with ind Mental Hygiene. s marked other than	To Be C	17. Father's Name (First, Middle, Last) Joseph N. Seitz				May (	ne (First, Middle, N Callahan		
and 2 sho ealth and I m 27 is m		19a. Informant's Name/Relationship (Type Norma L. Seitz	/ wife	1406	Midmeadov	w Road; 1	OWSON, M	D 21286	<u> </u>
parmit. Pages 1 and 2 Department of Health a Important: If Item 27 it any injury or other tra		20a. Method of Disposition  1 Burial 2 Cremation 3 Re  4 Donation 5 Other (Specify)	Dula Dula	aney Val		rdens 5/16		imonium,	ity or Town, State
Departition of the property of		21. Signature of Fuheral Service Liderse	Lig	Жu		n Funeral		Towsor	York Road n. MD 21204
Physician /Medical		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequ	Failur ience of):	16			st,	Approximate Interval Between Onset and Death
ate be executed any system and he burial-transit	cai Examiner	Sequentially list conditions, if any, leading to maniediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	ience of):	ystic b	idney d	hsease		years.
The law requires that the death certificate are has been signed by the attending physpage 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	ac. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3 -	Ectopic pregnancy Other (specify)	,		23d. Date (	
w requires that been signed be should be deta	by	Part II. Other significant conditions con	tributing to death but not resu	ilting in the un	derlying cause giv	en in Part I.	23e. Did tob	1-4	ute to the cause of death?
	Completed							prid dea No 1 E	ere autopsy findings available or to completion of cause of ath? Yes 2 \sum No
	tion; To Be	25. Was case referred to medical examiner?  1 Yes 2 TNo  27. Manner of Death  1 Natural 5 Pending investigation	ospital: 1 ☐ Inpatient 2 ☐ 8  28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. Injun Wor	er: 4 □ Nursing H y at	th (Check only one one 5 Resider 28d. Describe hor	nce 6 A ther	
To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral v	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hos building, etc. (Specify		eet, factory, office		28f. Location (Str. City or Town,		or Rural Route Number,
e Hospit 124 hours se Funera	edicai (		ician: To the best of my know er: On the basis of examinat and manner stated.						
To the To the To the Comp	Me	29b. Signature and title of certifler	w		29c. Licens				Month, Day, Year)
841		30. Name and address of person who cor	mpleted cause of death (Item	23a) (Type, I	Print) NEES ST	Baltri	nare:	m) 2	1204
S Regis	tate	31. Date filed (Month, Day, Year) MAY 1 6 2	32. Redistrar's Signat	JS A	porte				

5/13/05 at 0135 AM

Oxivel

LOBERT SEITZ

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amends items 8 10e 19b per fb 8844 6-17-05 vt
State of Maryland/Debarment of Health and Mental Hyolehe

		1 - For State Registrar	Otate of Ivie	arytaria / t		tificate of i		a wient		eg. No.	005	164	10
Physic	an	1. Decedent's Name (First, Middle, La	st)					M	ate of Deat onth	Day	Year	3. Time of	Death
/Medi	cal	Dale Schlenker				4h Cih. Tourn	l casting of D	May		11,	2005	1352	М
Exami	ner	4a. Fecility Name (If not institution, given Montgomery Hospic		use		4b. City, Town, or Rockvill		eath		1	County of Death Ontgomer	У	
Funeral Director		218-54-9819	Sex 7. Age 1□M 2፟M F 49	e (In yrs. last bii	rthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours N	Hrs. 8. Da Min. (M Jul	ate <b>b</b> ( <b>8</b> irth form, Day, y <del>17</del> ,	Year) 1955	9. Birthp Cour Mary	olece (State o ntry) Land	or Foreign
and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Tow	m or Loc	cation					1	0d. Inside Ci	ity Limits
Maryi -f sho	ρ	Maryland Montgome	ry	Silver	Spi	ring						1 🗆 Yes	2 <b>X</b> ] No
with the 3a or 28a	I Director	10e. Street and Number 161ds 1707 Mernfields D	; rive			10f. Zip Code 20906				-	en of What Cour		
filed within 72 hours after death with the Maryland Hygiene.  Hygiene.  other than "natural, or itams 23s or 28s-f show ent, the Medical Exacilization to the rediffied at	by Funeral	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces?  1  Yes 2 N N Yes, Give Year or Dates:			Vas Decedent of H Yes, specify Cuba ☐ Yes 2X No	ispanic Origin' n, Mexican, Pi Specify:	? (Specify Y uerto Rican	es or No- , etc.)		4. Race - Americ Black, White, Specify: Whi	etc.	
72 hou		15. Decedent's E (Specify only highest gr	ducation	16a	. Deced	ent's Usual Occup	ation	working		16b. Kin	nd of Business/In-	dustry	
within 72 ho jiene. Ir then "natur	Completed	Elementary/Secondary (0-12)	College (1-4or 5			kind of work done o				D - 1-		1	
led w tygier her th		12 17. Father's Name (First, Middle, Last	*)	Pri	incip	al Adminis	18. Mother's				anical G	ardens	3
uld be fi Mental H rked of	Fo Be	Richard Carl Sch						is Ron					
permit. Pages 1 and 2 should be filed within Department of Health and Mental Hyglene. Important: if item 27 is marked other than any injury or other traumatic event, trains once.		19a. Informant's Name/Relationship (Raymond Edward Ma		band 1	707	Herritel	ng <b>Yuge</b> ro ds Dri	r Rural Roui ve, Si	te Number. Llver	City or Spr	Town, State, Zip	<sub>Соде)</sub> ryland	2090
Pages 1 and the next of the next of the next of the next of the next or other next or		20a. Method of Disposition 1 □ Burial 2 ত Cremation 3 □ 1 □ Donation 5 □ Other (Speci		cemete	ну, степ	sition (Name of natory or other plac y im, Inc.	e) Мај 20	y 13°, 05			eation · City or To		ıd
permit. Departm Importa any inju		21. Signature of Funeral Service Lice		100198	Ro	Name and Address ckville, ckville,	Inc. 3	obert	A. P Mon	umpl	nrey Fun mery Ave	eral H nue	lome
Physician /Medical Examiner	_	23a. Part 1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	a. Metasta Due to (or as	tic Bre a consequence	ast of):		g, such as car	diac or resp	iratory arre	est,		Approximat Interval Bet Onset and I	ween
uted d ansit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease or injury) that initiated events	c.	a consequence	OI):								
rdificate be executed ng physician and sas the burial-transit		resulting in death) Last		a consequence	of):								
ndificate ng phys	Medical			-11									
The law requires that the death centre has been signed by the attending to be detached for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death		Ectopic pregnancy Other (specify)				2	3d. Date of delive Month		Year
ires that signed b	þ	Part II. Other significant conditions	contributing to death be	ut not resulting i	in the un	iderlying cause give	en in Part I.	2	3e. Did tob 1 □ Ye		se contribute to the		death?
The law requir ate has been si page 2 should	Completed							-	4a. Was ar autops perform	n y ned?	24b. Were auto	mpletion of c	available ause of
	0	25. Was case referred to medical					26. Place of			B)	1 1 1 1 1 1 1	26,140	
hysician: this certifical	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1Inpatie	nt 2 ER/O	utpatient	t 3□ DOA Oth	er: 4 🗆 Nursir	ng Home 5	Reside	nce 6		/ Hosp	ice
Ing F	atlon:	27. Manner of Death  1 X Natural 5 Pending 2 Accident investigation		y Year) 28b.	Time of Injury	28c. Injun World	at at	28d. D	escribe ho	w injury	occurred		
ipital or Att ours efter de eral Directi filled in by t	Certification;	3 Suicide 6 Could not to determined		ury - At home, fa c. (Specify)	arm, stre	eet, factory, office			ocation (Str ity or Town		Number or Rura	l Route Num	ber,
Hos Fun ely	edical	29a. Certifier 1 Certifying P (Check only one) 1 Medical Exa	hysician: To the best of miner: On the basis of and manner sta	examination ar	e, death nd/or inv	occurred at the tin estigation, in my o	ne, date and pointion, death of	lace, and du occurred at t	e to the ca he time, da	use(s) a ate and	and manner as si place, and due to	ated. the cause(s	i)
To the within 2 To the complet	X	29b. Signature and title of certifier	- 81/11H.							9d. Date	signed (Month,	Day, Year)	
		Ment	W				1218			5/	12/0	5	
20		30. Name and address of person who Charles Harrison	completed cause of d 1355 Picc				Le, Mar	yland	2085	0	•		
St Regist	ate rar	31. Date filed (Month, Day, Year) MAY 1 6	2005 32. Jegistra	ar's Signature	4	arte							

DHMH 17 Rev 1/2001

		•	State of Maryland / De	partment of Health a ertificate of Death	nd Mental Hy	/giene Reg. No. 2005 1011
ľ	0		Decedent's Name (First, Middle, Last)		2. Date of Do	eath 3. Time of Death
	Physicia /Medic		Betty Bertha Shanklin		May 12	2, 2005 Yeer 10:40AMM
	Examin	er	4a. Facility Name (If not institution, give street and number) 7827 Wendover Avenue	4b. City, Town, or Location of Baltimore	Death	4c. County of Death Baltimore
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthd) 82 Yrs	Months Days Hours	Min. Feb. 20	9. Birthplace (State or Foreign Country), 1923 West Virginia
	and *		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits
	Maryli	tor		ville		1 □ Yes 2 🕅 No
	vith the	Funeral Director	10e. Street and Number 7827 Wendover Avenue	10f. Zip Code 21234		10g. Citizen of What Country? United States
1	Jeath In 234	eral	11. Marital Status 12. Was Decedent Ever in U.S. 1	3. Was Decedent of Hispanic Orig	in? (Specify Yes or N	
9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Dep irrinent of Health and Mental Hygiene. Dep irrinents if them 27 is marked other then "naturel", or items 23a or 28a-f show any injury or other treumatic event, I're Medical Examinating must be notified at once.	by	Armed Forces?  1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican,  1 Yes 2 No Specify:	Puèrto Rican, etc.)	Black, White, etc.  Specify: White
ָ ה	72 ho natura	eted	15. Decedent's Education 16a. De (Specify only highest grade completed) (G	cedent's Usual Occupation	of working	16b. Kind of Business/Industry
7	within ane. then "	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	ive kind of work done during most b. DO NOT use retired) Sembly Worker		Electronics
ט ב	Hygie other ent,	a)	10 yrs. AS 17. Father's Name (First, Middle, Last)		's Name (First, Middle	
9	should be filed with mid Mental Hygiene I marked other the umatic event, the limits of the line in the	To B	Steven Boyd	Son	ja Klasn	a
Ě	l 2 sho n and l ris ma			-		per, City or Town, State, Zip Code)
ע .	1 and 2 Health 16m 27		20a Method of Disposition 20b. Place of Di	O Harbour Point	Date POI'C	Orange, FL 32127  20c. Location - City or Town, State
	Pages ent of nt: If it ry or c			rematory or other place) Service Corp. 5	/18/2005	Towson, Maryland
	perrit. Pag Dep rtment Importent: I any injury o		21. Signature of Funeral Service Licensee Michael E. Canapp	22. Name and Address of Facility 5305 Harford Ro	Leonard	J. Ruck, Inc. ore, Maryland 21214
			23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause or each line.			
P	hysician		Immediate Cause (Final disease or condition	ed myor	ardial	2 Offer of Onset and Death
	/Medical Examiner		resulting in death)  Du to (or as *consequence of):	0.44	antak	911
		ē	Sequentially list conditions, if any, leading to immediate  b. Due to (or as a consequence of):	conary	auer	z acsease
	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	& Left Vents	icular o	Contractility
,	icate be executed physician and sthe burial-transit	I Ex	resulting in death) Last  Due to (or a a consequence of):	,		
00/00	physicate to be the t	edical	d			
<b>Y</b>	anding use a	In/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	2 DEstanta aragnanas		23d. Date of delivery
	w requires that the death certific been signed by the attending p should be detached for use as	Physician/M		3 □Ectopic pregnancy 5 □ Other (specify)		Month Day Year
U.S. T	ries that signed b	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	17.70	tobacco use contribute to the cause of death?  Yes 2 □ No 3 □ Probably 4 ☑ Unknown
2	w requ	letec	History Prop : Som in			
מ ל	ician: The lay certificate has rector, page 2	Completed	fight corp. as the		auto	
1	clan: ertifica actor, p	Bec	25. Was case referred to medical examiner?		of Death (Check only	
5	ding Physician: The h. After this certificate ha funeral director, page	. To	1  Yes 2 No  Hospital: 1  Inpatient 2  ER/Outpa 27. Manner Death  28a. Date of Injury 28b. Tim			idence 6 Other (Specify) how injury occurred
5	th: After: After	tlon	1 Natural 5 Pending (Month, Day Year) Injur			now injury occurred
	To the Hospitel of Attending Physician: The law requires that the death certify within 24 hours after dense. The Trothe Funerel Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury · At home, farm, building, etc. (Specify)	street, factory, office		(Street and Number or Rural Route Number, wn, State)
- 4	l o the Hospitel or within 24 hours afte To the Funerel Dir completely filled in	edical C	29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/one)  Amount of the desired form of the basis of examination and/one and manner stated.	eath occurred at the time, date and investigation, in my opinion, death	place, and due to the occurred at the time.	cause(s) and manner as stated, date and place, and due to the cause(s)
1	Mithin To the To the Comple	Mec	29b. Signature and title of certifier	29c. License number		29d. Date signed (Month, Day, Year)
,	1		Tames Waylas Clarko	カム D0031476		5/13/05
6	X		30 Name and address of person who completed cause of death (Item 23a) (Type 7505 05/07 07.		SON, K	1) 21204
	Sta	te	31. Date filed (Month, Day, Year). 32. Redistrar's Signature	1		

			For State Registrar	State of	Maryland / Dep <i>Ce</i>	artment of <i>rtificate o</i> i			ene g. No.2 0 0 5	16412			
	Physic /Med		Decedent's Name (First, Middi		WAGNER SOLTI	ΕR		2. Date of Death Month Mav	Day Year 12, 2005	3. Time of Death			
	Exami	ner	4a. Facility Name (If not institution Blakehurs	st		To	or Location of Dea	th	4c. County of Death	ore County			
	Funeral Director		5. Social Security Number  345–14–2678  Usual Residence of Decedent	6. Sex 7. 1 ☐ M XXF	Age (In yrs. last birthday)  82  Yrs.	If Under 1 Yea Months Days				place (State or Foreign ntry) ago Illinoi			
	he Marylan 28a-f show ctiffied at	Director		timore	10c. City, Town or Le					10d. Inside City Limits 1 ☐ Yes 3√√No			
	s 23e or 2	ral Dir		Joppa Road	<i>‡</i> 753		21204		g. Citizen of What Cou USA	ntry?			
9800	72 hours after death with the Maryland naturel', or items 23e or 28e-f show alcal Examirer must be multiled at	by Funeral	11. Marital Status  1 □ Never Married 2 ☑ Marria  3 □ Widowed 4 □ Divorced	If Vas GivaX	es? TXNo	Was Decedent of If Yes, specify Cul 1 ☐ Yes 2 💆 No		Specify Yes or No- to Rican, etc.)	14. Race - Ameri Black, White, Specify: wh:	etc.			
21215-0036	d within jiene.	Completed	15. Deceden (Specify only higher Elementary/Secondary (0-12)	t's Education st grade completed)  College (1-4a)	(Give	DO NOT use retir	during most of we	orking 16	Sb. Kind of Business/In	,			
and ;	be filed htal Hyg ed othe event,	Be	17. Father's Name (First, Middle,	Last)	Orran Haanan	nome	7	me (First, Middle, Ma	•	e			
Maryland	12 should h and Men 7 le marke reumatic	2	19a. Informant's Name/Relations	hip (Type, Print)					City or Town, State, Zip	Code)			
Baltimore, I	ages 1 and 2 should nt of Health and Mer t: If item 27 le marke y or other treumatic		George D. Sol	3 □Removal from Sta	20b. Place of Dispo cemetery, crer	sition (Name of natory or other pla	асе)		204 c. Location - City or To	own, State			
Baltir	permit. Pages of Popartment of Popartment of Popartment: If ite any injury or ot once.		*4 Donation 5 Other (St. 21. Signature of Funeral Service		Mi	Name and Addr tche11-V	ess of Facility Viedefeld	Funeral H 1timore, N	ltimore, M Home, Inc.	D			
	ficate be executed WM-4 Medician and physician and its fine buriat-transit	dicai Examiner	23a. Ant 1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter the density that in	a. Due to (or a c.	i iin e.	sequence of):							
O. Box 6	death certi e attending id for use a	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		2 Fetal death 3 at time of death 5	Ectopic pregnanc Other (specify)	у		23d. Date of delive Month	ny Day Year			
ords, P.	law requires that the as been signed by th 2 should be detache		Part II. Other significant condition  Atrial Fibro	ns contributing to death	but not resulting in the un	iderlying cause gr	ven in Part I.	23e. Did tobac	co use contribute to the	e cause of death?			
tal Records,	The ate h	e Completed	25. Was case referred to medical					24a. Was an autopsy performed 1 Yes 2	prior to con death?	osy findings available npletion of cause of 2 No			
Division of Vital	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely tilled in by the tuneral director.	ertification: To B	examiner?  1 Yes 2 No  27. Manner of Death  1 Hatural 5 Pending 2 Accident investig 3 Suicide 6 Could n 4 Homicide	e 6  □Other (Specify njury occurred									
2	Hospital or 24 hours afte Funerel Dir tely tilled in	edicai Cert	29a. Certifier 1 Certifying	Physician: To the best	etc. (Specify)  It of my knowledge, death of examination and/or invitated	occurred at the tire	City or Town, S	0/2/ 22 4	ated.				
r,	To the within 2 To the comple	Σ	29b. Signature and title of certifier	Rebain III	mo	29c. Licens	e number	29d.	Date signed (Month, D	Day, Year)			
	6		30. Name and address of person TREDEL W IG 31. Date filed (Month, Day, Year)	the completed cause of	death (Item 23a) (Type, F	N CHAR	155 ST B	ALTMORG	MD 2121	2 '			
	Sta Registr	te ar	31. Date filed (Month, Day, Year) MAY 1	6 2005 32. Rigis	trar's Signature								

			Please I						Are Legible.	
			For State	State of Ma	ryland / Depa			Mental Hyg	giene	10110
			Registrar		Cei	rtificate of	Death		leg. No. UUJ	10413
	Physici	an ·	Decedent's Name (First, Middle, Last)			CNVDE	n	2. Date of Dea Month	Day Year	3. Time of Death
	/Medic		LENA		Α.	SNYDE		May	11th 2003	
	Examin	er	4a. Facility Name (If not institution, give	street and number)	11.	4b. City, Town, o	r Location of Deat	2 \	4c. County of Dea	
E			5. Social Security Number 6. Sex	1 07 02	(huse last historial)	If Under 1 Year	If Under 24 Hrs.	a ty	O Pie	N/A thplace (State or Foreign
	Funeral Director		,	M 2QF /. Age	(In yrs. last birthday) 97 Yrs.	Months Days	Hours Min.	8. Date of Birth	968 S	RUSSIA
			Usual Residence of Decedent	^	31	l		1 20.19.	1300	1000111
	yland		10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
:	Mar Filed	tor	MD N/A		BALT	IMORE				1 X Yes 2 No
:	th the	Directo	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	
	72 hours after death with the Maryland Inatural; or Itema 23a or 28a-f show dical Examiner must be notified at	ai	7218 PARK HEIGHT	S AVENUE			21208			USA
	r dea	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S. 13.	Was Decedent of H	Hispanic Origin? (S an, Mexican, Puerl	pecify Yes or No- o Rican, etc.)	14. Race - Am- Black, Whi	
92	or li	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 💢 No If Yes, Give	0	1 ☐ Yes 2 🎇 No	Specify:		Specify:	WHITE
215-003	"natural",		3 X Widowed 4 □ Divorced	Year or Dates:		dontin House Coour	ation		16h Kind of Business	/Industry
<u>က်</u> ျ	C * 01	Completed	15. Decedent's Edu (Specify only highest grade	e completed)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of word	rking	16b. Kind of Business	vindustry
12	filed within Hyglene. sther than "	mc	Elementary/Secondary (0-12)	College (1-4or 5+	-)	MAKER	-,		OWN HOME	
0	filed within I Hyglene. other than vent, It e M	Ö	17. Father's Name (First, Middle, Last)		110112		18. Mother's Nar	ne (First, Middle,	Maiden Sumame)	
<u>a</u>	9 d to 9	To Be	ALEXANDER		ITZK	OFF	DRAZA		(U)	OBTAINABLE)
Maryland	d 2 should be th and Menta 7 Is marked traumatic ev	-	19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Maili	ng Address (Street	and Number or Ru	ıral Route Numbe	r, City or Town, State,	Zip Code)
	12 e 17		STEPHEN EHUDIN /	COUSIN	34 0	AKRIDGE	COURT - I	.UTHERVII	LE, MD 210	)93
w ·	s 1 and if Healt Item 2 other		20a. Method of Disposition		20b. Place of Dispo	osition (Name of matory or other pla	ce)	Date	20c. Location - City or	Town, State
Ê	Pages nent of int: If It		1 💢 Burial 2 ☐ Cremation 3 ☐ R `4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State	1	UNG MEN		13/2005	WOODLAWN	N, MD
=	permit. Page Department of Importent: If any Injury or once.		21. Signature of Funeral Service License	ee 0 1/1/		2. Name and Addre			SON & BROS.	<del></del>
Ö	Per la		Stott VII.	atter	۶ ا	900 REIS			PIKESVILLE	
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	ications that caused	the death. Do not en					Approximate Interval Between
F	Physician		Immediate Cause (Final disease or condition	C 02 05	مديليه	hear	1.24	~		Onset and Death
г	/Medical		resulting in death)	Due to (or as a	consequence of):	1 20-	1 -1011	1010		13 years
l	Examiner		Commented to the annual street	myo	Lakas	intar	nalto	1		Iweek
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		consequence of):		\ ,			
	cuter	Examiner	Cause (Disease or injury that initiated events	atter	osclerot	rie he	ert (	Juscisa		15 years
,60	e exe ian e urial-		resulting in death) Last	Due to (or as a	consequence of):					•
376	death certificate be executed e attending physician end od for use as the burial-transit	licai		d						
× 68	ertific ling p e as	Physician/Medi	IF FEMALE:	10-16	4					
Box	ath ca ttend or us	ian/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of 1☐Live birth 2	Fetal death 3	Ectopic pregnanc	у		23d. Date of de Month	livery Day Year
o	0 0	/sic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□ Pregnant at t 9□ Unknown	ime of death 5 L	Other (specify)				
٠.	The law requires that the dei ste has been signed by the a page 2 should be detached f	Ph	Part II. Other significant conditions cor	ntributing to death bu	t not resulting in the u	inderlying cause giv	ven in Part I	23e. Did to	bacco use contribute t	o the cause of deatb?
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ě	e law has l	Completed						24a. Was autop		utopsy findings available completion of cause of
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=	sicien: The law s certificate has l lirector, page 2 s	Be	25. Was case referred to medical examiner?	lospital:	- 5 - 5 - 5 - 5 - 5 - 5 - 5 - 5 - 5 - 5	- O#	ner	ath (Check only or		
ō	I or Attending Phys after death. Director: After this I in by the funeral dii	. To	1 ☐ Yes 2 ☑ No 27. Manger of Death	1 Inpatier		II 3 DOA	4 🗆 Nursing r		lence 6 Other (Spenow injury occurred	acity)
0	ding h. After fune	tion	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injun (Month, Day	Year) Injury	Wo	rk? ]Yes 2∐No		. ,	
Division of	Atten deal ctor	fica	3 Suicide 6 Could not be	28e. Place of Inju	ry - At home, farm, st	reet, factory, office			Street and Number or F	lural Route Number,
	after after Dire	Certification:	4 Homicide	building, etc.	(Specify)			City or Tow	m, State)	
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, for the funeral director, for the funeral director, it is not the funeral director.		29a. Certifier 1 Certifying Phy	sician: To the best o	f my knowledge, deat	h occurred at the ti	me, date and place	e, and due to the	cause(s) and manner a	s stated.
	ne Ho	Medical	(Check only 2 Medical Exami	ner: On the basis of and manner stat	examination and/or in ed.	ivestigation, in my	opinion, death occi	urred at the time, o	date and place, and du	e to the cause(s)
	To the Comp	Σ	29b. Signature and title of certifier	2 0 0	-	29c. Licens	se number		29d. Date signed (Mon	
	X		ECK	elle	N.D.	15	25-0	00	May 11	,2005
18	( )		30. Name and address of person who co	ompleted cause of de	eath (Item 23a) (Type	Print)	١.	11	DIII	,2005
10			Edward 1	adda	C1.M.	Sina	Hosp	sta-1 8	1 Dalti	ugue
	Sta Registi		31. Date filed (Month, Day, Year) MAY 1 6 28	05 32 Registra	r's Signature					
	negisti	E.U	1071 - U Z01	US LIGHTER	I Kr Kill					

DHMH 17 Rev 1/2001

Lena Snyder

Patient Knun

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrer Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Month Year 11, 2005 MARY FRANCES May 7:05 A. M TIGHE /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Gilchrist Center Towson Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day Year) | Min. | March 13, 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□M 2√2F 1923 82 Yrs 216-16-3542 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1XYes 2 □ No Maryland N/A Baltimore Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21212 1015 E. Lake Avenue U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status l □Yes 2 XNo fYes, Give 1 X Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 🎇 No Specify: Š 3 Widowed 4 Divorced Year or Dates: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry s 1 and 2 should be filed within the Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 years Clerk Telephone Co. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 2 Michael Joseph Tighe Agnes Elizabeth Kilduff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1015 E. Lake Ave. Baltimore, Agnes Elizabeth Tighe (sister) Maryland 21212 altímore, 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of P Important: It its any injury or ot once. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) St. Mary's Church Cem! 5-14-05 Baltimore, Maryland 22. Name and Address of Facility
Mitchell-Wiedefeld Funeral Home, Inc.
6500 York Road Baltimore, Maryland 21212 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Bowel obstruction Immediate Cause (Final disease or condition resulting in death) SMALL Physician welks /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has birector, page 2 s autopsy performed? Yes 2200o 1 Yes 2 No 1 Yes Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: Hospital or Attanding Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide \*\*Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

\*\*Differentiation\*: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

\*\*Differentiation\*: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) To the 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

tegistrar MAY 1 6 200

31. Date filed (Month,

BINC 6701 N. Charles St. Bolts, Md 2120x 32 Jegistra's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

05-3338 B.K.S HELEN THOMPSON

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ĽΝ	THOMPS	ON	1 - For State Registrar	State o	f Maryla	nd / Depa	artmer <i>rtificat</i>			and M	ental H	ygien Reg. N	/ 111	15	164	15
			Hegistrar     Decedent's Name (First, Middle, La	st)			tinout				2. Date of I	Death			3. Time of	f Death
			Helen		Th	ompson					Month MAY	13.	2005	Year	1330	PM
			4a. Facility Name (If not institution, give	re street and nu			4b. City,	Town, or	Location o	of Death	1411	+-	c. County o	of Death	1 1000	
	es that the death certificate be executed Table 1 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  Important: If item 27 is marked other then "neturel", or items 23e or 28e-f show and in propriant: If item 27 is marked other then "neturel", or items 23e or 28e-f show and in propriant: If item 27 is marked other then "neturel", or items 23e or 28e-f show and in propriant: If item 27 is marked other then "neturel", or items 23e or 28e-f show and in propriant: If item 27 is marked other then "neturel", or items 23e or 28e-f show and in propriant: If item 27 is marked other then "neturel", or items 23e or 28e-f show and in propriant: If item 27 is marked other then "neturel", or items 23e or 28e-f show and in propriant: If item 27 is marked other then "neturel", or items 23e or 28e-f show and in propriant: If item 27 is marked other then "neturel", or items 23e or 28e-f show and in propriant: If item 27 is marked other then "neturel", or items 23e or 28e-f show and in propriant: If item 27 is marked other then "neturel", or items 23e or 28e-f show and in propriant: If item 27 is marked other then "neturel", or items 23e or 28e-f show and in propriant: If item 27 is marked other then "neturel", or items 23e or 28e-f show and in propriant: If item 27 is marked other then "neturel" and "neturel" a		600 LIGHT STREE	T APT. 2	214		BAL	TIMO	RE CI	TY				N/A		
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	Director		213-24-3207	1□M 2∏F	79	Yrs.					Feb.	5, 1	926	Sout	h'Caro	olina
	and		Usual Residence of Decedent  10a. State 10b. County		10c. (	City, Town or Lo	ocation			-					10d. Inside C	ity Limits
	fsho	ō	Marvland n/a		Ro	tlimore									1 ☐Yes	2 □ No
	283	rect	Maryland n/a  10e. Street and Number		Do	CIIMOI	10f. Zij	o Code				10g. (	Citizen of W	hat Coul		
3	39 O		600 Light Street	Apt. 21	.4			212	230				Unite	d St	ates	
	ms 2	nera	11. Marital Status	12. Was Dec	edent Ever in	U.S. 13.	Was Dece	dent of Hi	spanic Orig	gin? (Spe	cify Yes or Rican, etc.)	No-		- Americ	can Indian,	
0	or ite	F	1 Never Married 2 Married	1 ☐ Yes If Yes, Gi		j	1 ☐ Yes		Specify:		,		Specify:		White	
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5	Hyg other ent,		17. Father's Name (First, Middle, Last						18. Mothe	r's Name	(First, Midd	de, Maid	en Sumame	e)		
land	lid be lenta rked lic ev	lo B	John Rowell							Inez	McGr	eoch				
<u>a</u>	and h	r	19a. Informant's Name/Relationship				-						or Town, S		Code) 21224	
			Robert Jackson (1 20a. Method of Disposition	repnew)	20h	. Place of Disp			Liee		ate		aryla:			
0	if ite		1 ☐ Burial 2 XI Cremation 3 [		State	cemetery, cre	matory or	other place						•	Mary1a	and
Бантішог	artme ortani injury		<ul> <li>4 Donation 5 □ Other (Special</li> <li>21. Signature of Funeral Service Lice</li> </ul>		De	yview (			1							1110
מ	lmp any any			. Wayne	0ster1	ing $\frac{Mc}{13}$	Cull;	y <del>-</del> Pol Fort	ynial Ave	k Fun . Bal	leral .timor	Home e, M	, P.A áryla	nd 2	1230	
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	uted d ansit	mln	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C												
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09/80	cate b physic the b	dica	•	d												
POX P	ath certif attending or use as	ian/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		tcome of precipint 2 E	etal death 3	⊒Ectopic p ⊒ Other (s						23d. Date Mon		•	Year
j.	the de by the	nysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unkn				poony)								
ds, r	es the gned be de	by	Part II. Other significant conditions	contributing to d	leath but not r	esulting in the u	underlying	cause give	en in Part I	•		id tobacc □ Yes	-1	bute to t 3 ☐ Prol	the cause of o	death?  Unknown
೮	> L) (/i	iete									24a. W		24b. W	Vere auto	opsy findings	available
r	The ate h page	Completed									1 Te	-	d	eath?	2 No	cause of
VItal	Physicien: The rithis certificate ral director, pag	o Be	25. Was case referred to medical examiner?  1 Xes 2 No	Hospital:	Inpatient 2	☐ ER/Outpatie	nt 3 D	OA Othe			(Check on		¥ ♥lOtho	r (Cassi	<sub>fy)</sub> at s	scene
O	Phys or this oral di	<b>⊢</b>	27. Manner of Death	28a. Date	of Injury	28b. Time o		28c. Injury Work					jury occurre		y) at 2	Joeric
0	death. ctor: After y the funer	atio	1 Satural 5 Pending 2 Accident investigated		nth, Day Year,	) Injury	М		Yes 2 🗌	No						
UIVISION	el or Atte s after de: Il Directo Id in by th	Certification:	3 ☐ Suicide 6 ☐ Could not determined	200. Place	e of Injury - A ling, etc. (Spe	t home, farm, st	reet, factor	ry, office		2	28f. Location City or	n (Street Town, St	and Numbe	er or Run	ai Route Nun	nber,
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Medical (	29a. Certifier 1 Certifying P	miner: On the b												s)
	To t To ti comp	Σ	29b. Signature and title of dertifier	has			29	c. License	number CME			29d. I	-	(Month, 200	Day, Year)	
•	/		- Utal	ella	/	02-1	D					1	,			
	2	(2)	30. Name and address of person who						n Sti	reet	Balt	imor	e, Ma	ryla	ind 212	201
	Sta Registr		31. Date filed (Month, Day, Year)	6 2005	Regionar's Sig	gnature /	A STATE OF THE PARTY OF THE PAR	Je Je								

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			1 - State of Maryland / Department of Healt Certificate of Dea	th	giene 005 16416
	Physic	ian	1. Decedent's Name (First, Middle, Last)  Virginia Louise Teufer	2. Date of Dea Month	Day Year
	/Medi Exami		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Locati	ion of Death	11 2005 1150 A M
	LAGIII	101	SINA HOSPINA OF BATIMUSE BATTI	MAHS CITY	BASTINICAS CITY
	Funeral Director		5. Social Security Number 214-38-5817  6. Sex 1 M 2 1 A ge (In yrs. last birthday) 64 Yrs.  1 Months Days Hou	nder 24 Hrs. 8. Date of Birtl urs Min. (Month, Da) Feb 1 2 /	th, Year) 9. Birthplace (State or Foreign Country) 41 MAryland
	yland		10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
	e Mar	Director	MD AnneArundel Severna PArk		1 ☐ Yes 2 🔀 No
	with the	Dìre	106. Street and Number 140 Wild Oak Road 21146		10g. Citizen of What Country?
	ms 23	Funeral	140 W11d Oak Road 21146  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic	Origin? (Specify Yes or No-	USA - 14. Race - American Indian,
Maryland 21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or itams 23a or 28a-f ahow int, tre Modical Exerctine must be redified at	by	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes ☑ No  11 □ Yes 2 ☑ No  1 □ Yes 2 ☑ No Specified Sp		Black, White, etc.  Specify:White
15-(	n 72 hours "natural", edical Exp	lete	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during in	most of working	16b. Kind of Business/Industry
212	d withi jiene. r than	Completed	Elementary/Secondary (0·12)  College (1-4or 5+)  1 vr  Secretary		Hopkins
pu	2 should be filed within 72 ho and Mental Hygiene. is markad other than "natur aumatic avant, tre Mulical	Be C		other's Name (First, Middle,	Maiden Sumame)
уlа	should the should the should the should the should be sh	٦ ا		irginia Jon	
Mai	s 1 and 2 should if Health and Men itam 27 is marka othar traumatic		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Num  140 WildOakRo		or, City or Town, State, Zip Code) 1Park MD 21146
	s 1 and 2 f Health itam 27 i		20a. Method of Disposition 20b. Place of Disposition (Name of	Date Date	20c. Location - City or Town, State
m	Page nent o ant: If ary or	3	1 □ □ □ □ □ Cremation 3 □ □ Removal from State ParkwoodCemetery	5/14/05	Baltimore MD
Baltimore,	permit. Pages Department of H Important: If its any injury or of		21. Signature of Funeral Service Licensee 22. Name and Address of Fa	connerry	FuneralHomeofEssex
			23a. Part 1. Enter the disease, or combinations that caused the death. Do not enter the mode of dying, such shock, or heart failure. Light only one cause on each line.	as cardiac or respiratory arr	rest, Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)  a. A CUTE RENALE	ALLUNG	Onset and Death
	/Medical Examiner		Due to (or as a consequence of):	AG C	
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	2)()	
	cate be executed physician and the burial-transit	Examiner	that initiated events C.		
8760,	cate be execu ohysician and the burial-trar	al E	Due to (or as a consequence of):		
687	flicate g phys	edical	d		
Вох	death certifi s attending d for use as	M/u	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of delivery
		Physician/Me	in the past 12 months?  1		Month Day Year
P.(	that the		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pa	art I 23a Did to	bacco use contribute to the cause of death?
Records,	se gu	Ω	a security is a security in the diagram of the security in the diagram of the security is a security in the diagram of the security in the security	1 🗆 Ye	
CO	aw requir s been si 2 should	Completed		24a. Was a	an 24b, Were autopsy findings available
		mo		autops perforr	med? death?
Vital	Physician: this certificanal director,		BX4IIIII BY	lace of Death (Check only on	
of	Phy ald	To	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Uppatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐	Nursing Home 5 Reside	
	Attanding I r death. actor: After by the funer	tion	27. Mann of Death  1 □ atural 5 □ Pending (Month, Day Year)  2 □ Accident investigation  28a. Date of Injury 28b. Time of Injury Work?  Month, Day Year)  28b. Time of Vork?  North?  48c. Injury at Work?		ow injury occurred
Division	I or Attandi after death. Diractor: A d in by the fu	Certification:	3 Suicide 6 Could not be determined determined building, etc. (Specify)	28f. Location (St	treet and Number or Rural Route Number,
ā	ital or rrs aft ral Dir led in			City or Town	
	To the Hospital or Atta within 24 hours after de To the Funaral Diract completely filled in by th	edical	29a. Certifier  (Check only one)  1☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date  2☐ Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, or and manager stated.	and place, and due to the ca	ause(s) and manner as stated. ate and place, and due to the cause(s)
	o tha		29b. Signature and tijke of certifier 29c. License numbe		29d. Date signed (Month, Day, Year)
	_/		Au & and MO DI	(140	MAY 11 200
	0	1	30. Name and address of person who completed cause of death (Item 20a) (Type, Print)	10 - 2 1	01-110
	V		31. Date filed (Month, Day, Yepr) a 222 32 Registrar's Signature	11 Le, 15	HUT, MU 21215
	Stat Registra	-	MAY 16 2005 32 Degistrar's Signature	/	,

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VIRCINIA TENERA

		For State Registrar	State of M	arylan	-	artmen rtificat			and Me		giene leg. No.2	005	16417
Physicia	n	1. Decedent's Name (First, Middle, EDWARD VAUGHAN	Last)						- 1	2. Date of Dea Month	th Day	Year	3. Time of Death
/Medica Examine		4a. Facility Name (If not institution, UNION MEMORIAL H					Town, or IMORE	Location of		7. 1000		ounty of Dea	- 1 10 1
Funeral Director		217 07 8908	3. Sex 7. Ag 1 <b>3</b> M 2 □ F	ge (In yrs. 1 89	ast birthday) Yrs.	If Under Months	1 Year Days	If Under: Hours	Min.	8. Date of Birth (Month, Pay LEB. 15	, Ye 191	9. Bir .6 VI	thplace (State or Foreign COINIA
Maryland a-f ehow	tor	Usual Residence of Decedent  10a. State  10b. County  MD	N/A		y, Town or Lo	cation							10d. Inside City Limits 1    Yes 2 □ No
with the	Director	10e. Street and Number 3801 ELKADER RD.				10f. Zip 212					10g. Citize	n of What C	ountry?
s s n n n n	by Funeral	11. Marital Status  1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? d 1 Yes 2 IV If Yes, Give Year or Dates:				lent of His	spanic Origin, Mexican		cify Yes or No- Rican, etc.)	14.	. Race - Am Black, Whi	erican Indian, te, etc. BLACK
within 72 hou liene	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)		5+)	16a. Deced (Give life. I	kind of wo DO NOT u	k done di	urina most	t of workin			of Business	/Industry
2 should be filed within and Mental Hyglene. is marked other than eumatic event, the Mental Hyglene.	lo Be C	17. Father's Name (First, Middle, La EDWARD VAUGHAN	ast)						or's Name	(First, Middle,	Maiden Su	ımame)	
d 2 sho th and 1 7 ie me treume		19a. Informant's Name/Relationshi BERNICE O. VAUGH			1	-	•			Route Numbe.	-		
Pages 1 and 2 ment of Health 8 ant: If item 27 is		20a. Method of Disposition 1 ★Burial 2 ☐ Cremation 3		1 0	lace of Dispo	sition (Nar	ne of ther place	)	Da	ate	20c. Loca	tion - City or	Town, State
t. Pages tment of t fant: If it		'4 ☐ Ponation 5 ☐ Other (Spe	ecity)	DRU				- 1					, MARYLAND
permit. Pages Department of I Important: If its any njury or o		21 Senature of Funeral Service Li	censee //	NE		. Name an 412 E							UNERAL HOME RYLAND 21213
Physician		23a. Part1. Enter the disease, or c shock, or heart failure. List of Immediate Cause (Final disease or condition	omp cations that cause nly one cause on each l	ine.		er the mod	e of dying	such as	cardiac or	respiratory arr	est,		Approximate Interval Between Onset and Death
/Medical Examiner	liner	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Poly Con as	a consequ	Hic	C	an	cer	-				years
ate be executed nysician and he burial-transit	ical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	a consequ	uence of):								
The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1∐Live birth 4∐Pregnant a 9∐Unknown	2 Fetal	Ideath 3	Ectopic pr					230	d. Date of de Month	livery Day Year
w requires that is been signed by should be deta	ò	Part II. Other significant condition	s contributing to death b	out not resu	ulting in the u	nderlying c	ause give	n in Part 1.	,		bacco use es 2□!		o the cause of death? robably 4 Unknown
	Completed				<u> </u>					24a. Was a autops perform	SV .	24b. Were as prior to death? 1 \(\sum \) Yes	utopsy findings available completion of cause of s 202No
icien: Sertific ector.	g Re	25. Was case referred to medical examiner?	Hospital:	o da			Othe	-		(Check only or		2011 / /2	
ng Pt	ation: 10	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investiga	28a. Date of Inju	ıry	ER/Outpatien 28b. Time of Injury		8c. Injury Work	4   Nu	2	sd. Describe h			icity)
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral completely fi	Certification:	3 Suicide 6 Could no 4 Homicide determin		jury - At ho tc. (Specif)	ome, farm, str	eet, factory	, office		2	8f. Location (S City or Tow	treet and M n, State)	lumber or R	ural Route Number,
To the Hospital within 24 hours to the Funeral completely filled	edical		Physician: To the best xaminer: On the basis of and manner st	of examina									
To the within To the compl	Me	29b. Signature and title of certifier				290	. License	number		2	9d. Date s	igned (Mon	th, Day, Year)
		30. Name and address of person w	apathy	death (lto-	2321 /7	Print	000	611	87		Mar	باللا	2005
5		Soumya Go	mapath	14, 1	M.D.	Uni	on '	Men	prid	J B	alti	more	, MD
State Registra	-	31. Date filed (Month, Day, Year)	2005 32. a gisti	rat's Signa	ture	neth	•						

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year GRACE L. VALENZIA /Medical 8, MAY 2005 7:10 A 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 203 GEORGIA AVE NE GLEN BURNIE ANNE ARUNDEL 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours Director 212.36.5034 APRIL 22,1939 DE Usual Residence of Decedent death with the Maryland 10a. State show 10b. County 10c. City, Town or Location ? Is marked other than "natural", or Items 23a or 28a-f shov traumatic event, If a Madical Examinar must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 ☐ No ANNE ARUNDEL MD GLEN BURNIE XX 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 203 GEORGIA AVE NE Funeral 21060 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Ite, any righty or other traumatic event, Ite Madical Examinal anse. 1 Never Married XX Married 1 ☐ Yes PV No If Yes, Give Year or Dates: 1 Yes XX No Baltimore, Maryland 21215-0036 Specify δ 3 Widowed 4 Divorced Specify: WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 SALES RETAIL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ್ತಿ JAMES COLLISON VIRGINIA JONES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RICHARD L. VALENZIA HUSBAND 203 GEORGIA AVE NE GLEN BURNIE, MD 21060 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State BAYVIEW CREMATORY 5.9.2005 BALTIMORE, MD 21. Signature Tuneral Service Lice se FINK FUNERAL HOME, P.A. weg GREGORY FANK MO1148 426 CRAIN HWY SW GLEN BURNIE, MD 21061 23a. Part 1. Inter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Frysician 0 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Under in Cause (Disease or injury that in its tod as our injury Examiner Due to (or as a consequence of) The law requires that the death certificate be executed as the burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of) Box 68760, attending physiciar Physician/Medical IF FEMALE: nse 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. the detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 99 page 2 should 1 Yes 2 No 3 Probably 4 XUnknown Completed 24a. Was an autopsy performed? 1 Yes 22 No 24b. Were autopsy findings available prior to completion of cause of death? certificate has 1 ☐ Yes 2 ☐ No Hospital or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 2 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 28b. Time of Injury Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Descrive how injury occurred After 1. Natural 5 Pending investigation after death.

Director: Af
in by the fur 2 Accident 1 Tes 2 No Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of pertition 29d. Pate signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type 3. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) May 11, Physician 6:51P.m DOROTHY 2005 MARY VOELKER /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Fecility Name (If not institution, give street end number) Examiner Oak Crest Care Center Baltimore Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, January 9. Birthplace (State or Foreign 14 Maryland 5. Social Security Number 7. Age (In vrs. lest birthday) Funeral Days Yrs 1914 213-58-2448 Director Usual Residence of Decedent daath with the Manyland 10c. City, Town or Location 10d. Inside City Limits 10a. Stete 10b. County e how permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel", or items 23e or 28s-f ehon any Injury or other traumatic event, the Maddeal Examiner must be northed at 1 ☐ Yes 2√√No **Funeral Directo** Maryland Baltimore Baltimore 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 8800 Walther Blvd 21234 USA 12. Was Decedent Ever in U,S. Armed Forces?, 1 ☐ Yes 2A No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Maritel Stetus 1 Never Married 2 Married 1 ☐ Yes XXNo Specify White Specify: \$ 3XXWidowed 4 □ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gertrude Elizabeth Fitzsommons William Aloysius Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeanne Voelker Tepel DTR 8203 Yorborough Road Towson, Maryland 21204 altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition XX Burial 2 Cremation 3 Removal from State Dulaney Valley Memorial Gardens 5/16/05 Timonium, Maryland ☐ Donation 5 ☐ Other (Specify) ignature of Funeral Service Licensee 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 nus ie, o./. mplications, hat wised the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one course on each line. 23a. Pert1. Enter the disease shock, or heart failure. Onset and Death **Physician** remorrhage Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or es e consequence of) Physician/Medical Examiner led by the attending physician and datached for use as the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Lest Due to (or es a consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Ves 2º No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: All Nursing Home Certification: To 1 Yes 2 N 5 ☐ Residence 6 ☐ Other (Specify) this erai Director: After thi 27. Menner of Death 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 No 1 ☐ Yes 2 Accident 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, Stete) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) or A after 4 Homicide To the Hospital within 24 hours a To the Funeral D Learlifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier

State Registrar

DHMH 16 Rev 6/95

8800

32. Registra/s Signature

30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mulle

31. Date filed (Month, Dey, Year)

amend item#10b-f, perfh, 6844, 6/13/05 TT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 05-12 1:55 Ам MARIAN B. WATKISS /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NA ROCK GLEN NURSING HOME BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 04.26.1910 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Months Hours 1 □ M 2 1 F Yrs. 056.12.9889 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10b. CountyN/A 10c. City, Town or Location 10a. State show Baltimore item 27 is marked other than "natural", or Items 23s or 28s-f shoi other traumatic event, the Medical Examinal must be rediffed at 1 Yes 2 HNO MD BALTIMORE GWYNN DAK Directo 10e. Street and Number 10 N. Rock Glen Road 21229 10g. Citizen of What Country? 10f. Zip Code 2121 WINDSOR GARDENS LANE 516 USA Completed by Funeral should be filed within 72 hours after death 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 KLNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Baltimore, Maryland 21215-0036 Specify: BLACK 3 Nidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) BALTO. COUNTY BD. OF ED. CUSTODIAN NIA 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be is marked o ARAMINTA MAY WILLIS JOHN ROBERT GREEN ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 CATONSVILLE, MID Health a 510 CARGIL AVE DELANO WASHINGTON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ö 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Depertment of Important: If any injury or once. DRUID RIDGE 05.16.05 PIKESYILLE 1 4 □ Donation 5 □ Other (Specify) VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATT PIKE BALTO. MO 21. Signature of Funeral Service Licensee PIKE BAID, MO . 21229 langh Approximate Interval Between Onset and Death 23a. Part1. Enter the bisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head ailure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Proysician 6 months Concinent Liver /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed nding physician and use as the burial-transit Due to (or as a consequence of): 68760 Physician/Medical Box IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy atter for L in the past 12 months? Month Day Year 5 Other (specify) 4□Pregnant at time of death P.O. the 9 Unknown þ signed b 23a. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 Yes 2 0 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t autopsy 1 ☐ Yes 2 ☐ No 1 Yes 2 certificate Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: ursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes No 2 this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide after within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner state. Medical 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature a D 43386 5.13.05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A. Euten Place, Baldinory ma 2/2/7 1714 Vaniel lloward 22. Registrar's Signature 16 2005 State HAR FELD Registrar

			1 - For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artmen ertificat			ınd M	-	giene Reg. No	000	1 27 1 15 1
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212	e filed within al Hygiene. other than ' vent, Ire Ma	Completed	Elementary/Secondary (0-12) 12th	College (1-4or 5	Labo		, , , , ,	,				istry	
b	be filed within 72 hours after death with the Marylan at all Hygiene.  All Hygiene.  Solution than "neturelt, or filems 23e or 28e-f show other than "neturelt," or filems 23e or 28e-f show ovent, it is Madical Examiner must be notified at	Be C	17. Father's Name (First, Middle, Last)					18. Mother	's Name	(First, Middle,	-		
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e,	1 and Health Sm 27 Sm 27		Doris Waters (wi 20a. Method of Disposition	fe)	3903	Norf	olk	Ave.		ilto.			
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≣	artme artme orteni injury		<ul> <li>4 □ Donation 5 □ Other (Specify)</li> <li>21. Signature of Funeral/Service License</li> </ul>		Garriso					-05	Reis	tersto	wn, MD
Ba	Dermi Depa Impo any ii		1/lesten	March 6								s Jr. ID 2123	
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			30 Name and address of person who com Seovae E. Will	公耳一	I.D. 3901	Print) Loc	hR	aven	Bou	ulevari	l,B	attimor	R MD. 21218
	Star Registra		31. Date filed (Month, Day, Year)  MAY 1 6 200	32. Registrar	's Signature	melle							

DHMH 17 Rev 1/2001

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	Examin		4a. Facility Name (If not institution, giv	e street and number)	-	4b. City, Town, o	or Location of Death		4c. County of Dea	
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	Funeral		5. Social Security Number 6. S	ex 7. Ag	e (In yrs. last birthda	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		thplace (State or Foreign ountry)
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	and *	ŀ	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
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	ns 23	Funerai	2718 Lodge For	12. Was Decedent	Ever in U.S. 13	3. Was Decedent of I	lispanic Origin? (Sp	ecify Yes or No-	14. Race - Am	erican Indian,
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	s 1 and 2 should be filed within 72 hours effer deeth with the Marylen if Health and Mental Hyglene if Health and Mental Hyglene from 23a or 28a-f show item 27 is marked other then "natural", or items 23a or 28a-f show other traumatic event. Its Medical Exercited for court the notified at			COII (WITE)		position (Name of			20c. Location - City o	
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			30. Name and address of person who	completed course of	leath (Item 22a) (Tim	pe Print)	7100	. 0	0 1	04.0
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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Maynth 13, 0451A. 2005 Physician Edward Hobbs Yingling, Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Parkville 7105 Chambers Road If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Pay, Year) Jan. 21, 1921 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 XM 2□ F 214-14-7189 84 Marylánd Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 ie marked other then "naturel", or Itema 23a or 28a-f ehow traumatic event, the Medical Examinat must be notified at 1 Yes 2 No Director MD Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7105 Chambers Road 21234 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Line Supervisor General Motors 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Edward Hobbs Yingling Mary Wrzbacher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 le eny Injury or other trat once. Mrs. Naoko Yingling- Wife 7105 Chambers Road Parkville, Maryland 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Hilltop Service Corp. 5/14/05 Towson, Maryland 21. Signature of Funeral Service Licensee Heather Cain 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Maryland 21214 Calla 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardwiasculas **Physician** Atheroscheronic /Medicai Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the attending physician and thed for use as the burial-transit law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 4 Pregnant at time of death 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performs 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6X Other (Specify) (SCENE) 1 XYes 2 No 2 ER/Outpatient 3 DOA Certification: To 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier OCME May 13, 2005 rechail. MI) Tamell, 30. Name and recess of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street Baltimore, Maryland 21201 Yamela E. Southail 31. Date filed (Month, Day, Year) State MAY 1 6 2005 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

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	286-1	Funeral Director	MD 10e. Street and N	-	ANNE'S	CH	ESTER	10f. Zip	Code				10g. Citizen of	What Cou	
	3 a or				TE DRIVE				619				USA	Wildt Ool	y.
	death	nera	11. Marital Status	IDOM OIL	12. Was Decedent	Ever in U	.S. 13.			spanic Orig	gin? (Spec	cify Yes or No lican, etc.)	o- 14. Ra	ce - Amer	ican Indian,
9	after or Ite	F.	1 🗌 Never Ma	rried 2 Marrie	Armed Forces'  1 X Yes 2 If Yes, Give		42-	1 Tes, spec 1 ☐ Yes 2			і, Риело н	lican, etc.)		ick, White	
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-1 show the Madical Examinat matter in Milled at	d by	3 🗌 Widowed	4 Divorced	Year or Dates:	194	¥5						Speci	iy: mi	HITE 
15-	n 72	lete			Education grade completed)		(Give	dent's Usua kind of wor DO NOT us	k done di	uring most	t of working	g	16b. Kind of E	Business/I	ndustry
12	withi iene. than	Completed	Elementary/Sec 12	condary (0-12)	College (1-4or	5+)	735	CUTT					FOOD		
þ	be filed within 72 hours after death with the Maryla hat Hyglene. Id other than "natural", or items 23s or 28s-1 show event, the Madical Examinational by	Be C	17. Father's Name	(First, Middle, L	ast)					18. Mothe	r's Name	(First, Middle	, Maiden Suma	me)	
<u>la</u>	thould be ad Mental marked c matic ev	To B	JOHN AV	ENI						ANNA	PETE	ROV			
Maryland	d 2 should th and Men 7 is marke treumatic	-	19a. Informant's f	Name/Relationshi	р (Туре, Print)		19b. Maili	ng Address	(Street a	nd Numbe	r or Rural	Route Numb	er, City or Town	, State, Zi	ip Code)
	5 = N L			NE AVENI	/WIFE					INTE			STER, MI	21	619
Baltimore,	00-		20a. Method of Di		3 □Removal from State		Place of Dispo cemetery, crei	sition (Nam matory or ot	ne of ther place	)	Da	ite	20c. Location	- City or T	own, State
Ë	nit. Pag artment ortant: I injury o		° 4 ☐ Donation	5 Other (Sp.	ecify)		WNSVII	_				/2005	CROWNS	SVILL	E, MD
Bal	permit. Departm Importa eny inju		21. Signature of F	Ineral Service L	censee Agg	get		2. Name and ELLOW: O6 SHA	d Address S, HI AMRO	s of Facility ELFEN CK RO	BEIN AD, (	& NEW!	NAM FUNI	ERAL 21619	HOME, P.A.
			23a. Part1. Enter shock, or he	the disease, or deart failure. List o	omplications that cause	ne deatl	h. Do not ent	er the mode	e of dying	, such as	cardiac or	respiratory a	rrest,		Approximate Interval Between
	Phy <del>sicia</del> n		Immediate Cause disease or condit	ion	Anta	rio	saler	otic	2 9	1.60	ent	1	SEAS	e.	Onset and Death
	/Medical Examiner		resulting in death	)	Due to (or as					100		101	00110		
	Cxammer		Sequentially list of		b										
	ed isit	Juner	cause. Enter Und Cause (Disease of	httriediats lerlying er injury	Due to (or as	a consequ	lience of):								
	xecut and al-trar	Examln	that initiated even resulting in death)	ts	c Due to (or as	a conseq	uence of):								
8760,	ate be executed nysician and he burial-transit	ical E				,	,								
9	ificate g phys as the				0.										
Вох	eath certifical attending phy I for use as th	Physician/Med	IF FEMALE: 23b. Was decede	nt pregnant	23c. If yes, outcome			7C-+i					23d. Da	ate of deliv	very
	deat	slcia	in the past 1: 1 Yes 2	□No	1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown			]Ectopic pre ] Other <i>(sp</i> e					M	onth	Day Year
P.0	that the de ned by the a detached f	2hys	9 🗌 Unknow		1,77										
Records,	9 P B	by	Part II. Other sign	ificant condition	s contributing to death t	out not resi	ulting in the u	nderlying ca	ause givei	n in Part I.			obacco use con Yes 2 🗀 No		the cause of death? bably 4 Durknown
S	law requir as been si 2 should l	Completed										24a. Was	an 24b.	Were aut	opsy findings available
Re	The lav	E O											ormed?	prior to co death?	ompletion of cause of
Vital		0	25. Was case refe	erred to medical	L					26. Place	of Death	1 ☐ Yes Check onl	2 <b>\</b> o	1 🗌 Yes	2□ No
of V	S S S	To B	examiner? 1 XYes 2	] No	Hospital: 1 🔲 Inpati	ent 2	VOutpatier	nt 3□ DO	A Other	r. 4 🗆 Nui	rsing Hom	e 5 🗀 Resi	dence 6 🗆 Oti	ner (Speci	ify)
n o			27. Manner of Dea	ath 5 🗀 Pending	28a. Date of Inju (Month, Da	ıry ıy Year)	28b. Time of Injury	28	Bc. Injury Work	at ?			how injury occur		
sio	Attending r death. sctor: After	catl	2 Accident	investiga 6 ☐ Could no	tion			М	1 🗆 Y	es 2 🗆 N	No				
Division	of the circle of	Certification;	4 Homicide	dotomic	ed 28e. Place of In building, e	jury - At ho tc. <i>(Specif</i> )	ome, farm, str y)	eet, factory,	, office		28	Bf. Location (: City or Tox		ber or Rur	al Route Number,
	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by		29a. Certifier	1 Certifying	Physicien: To the best	of my kno	wledge, deat	n occurred a	at the time	e, date and	d place, ar	nd due to the	cause(s) and m	anner as s	stated.
	the Ho in 24 the Fu ipletely	edical	(Check only one)	2 Medical E	xaminer: On the basis of and manner st	of examinal	tion and/or in	vestigation,	in my opi	inion, deat	h occurred	d at the time,	date and place,	and due t	to the cause(s)
	With To To	Σ	29b. Signature an	d title of certifier	n I	)ep.	utel	29c.	License	number	05	4	29d. Date signe	ed (Month,	Day, Year)
,			Ull	lle	1	in	0'						4/2	110	)
0	XKK		Me	liAm	Postar	death (Item , B	23a) (Type,	Print)	15	B	nev.	icA	210	35	
	Sta Registr	100	31. Date filed (Mo	APR 2	5 2005 32. Regi	rar's Signa	ture /	freed	2	V			and and place, 29d. Date signe		
								-							

anend item 23 aper or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Mary	rland / Dep	artment of rtificate c			Reg. No:	5 16425
	Physici		Decedent's Name (First, Middle, Last)     PATRICIA	DIANE		BYRD		2. Date of De APRIL		Year 2:50 AM
	/Medio Examir		4a. Facility Name (If not institution, give s	street and number)		4b. City, Town	n, or Location of D	Death	4c. County of MONT	of Death
	Funeral Director		5. Social Security Number 6. Sey 577-62-2153		yrs. last birthday, 9 Yrs.	If Under 1 Ye Months Day		Hrs. 8. Date of Bin Min. Month Da MARCH	15,1946	9. Birthplace (State or Foreign WASHINGTON, DC
	e Maryland Sa-f ehow	ctor	10a. State 10b. County  MD MONTGOME		c. City, Town or L		ERMANTOWI	N		10d. Inside City Limits 1 X Yes 2 ☐ No
	with th	Dire	10e. Street and Number	77		10f. Zip Cod			10g. Citizen of W	hat Country?
036	permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Heelth and Mental Hygiene. Importent: If Item 27 is marked other than "natural', or items 23e or 28e-f ehow minpurportent: If item 27 is marked other than "natural', or items 23e or 28e-f ehow any injury or other treumatic event, the Medical Engini or must be notified at annes.	by Funeral Director	19515 FREDERICK  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1Yes 2No If Yes, Give Year or Dates:	r in U.S. 13.			? (Specify Yes or No Juerto Rican, etc.)	USA  14. Race Black Specify:	- American Indian, c, White, etc. WHITE
Baltımore, Maryland 21215-0036	ed within 72 ho rgiene. Ier than "natur I, the Medical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 1 2	cation e <i>completed)</i> College (1-4or 5+) 4	(Give	DO NOT use rei	ne during most of tired) ACHER		SCHO	MERY COUNTY OOLS
yland	ould be file Mental Hy arked oth	To Be (	17. Father's Name (First, Middle, Last) ORLANDO	W.	ALTIMO		DIA	Name (First, Middle, ANE	G	GRIMALDI
Mar	d 2 shu th and th sm treum	8 9	19a. Informant's Name/Relationship (Ty ALAN R. BYRD	pe, Print) HUSBAND		ng Address (Stre 5 FREDER		GERMANTOW	•	State, Zip Code) LAND 20876
more,	Pages 1 en nent of Heel ent: If item 2 ury or other		20a. Method of Disposition 1 🛣 Burial 2 □ Cremation 3 □ R 1 4 □ Donation 5 □ Other (Specify)	emoval nom State	20b. Place of Disposemetery, cre	osition (Name of matory or other)	place)	Date	20c. Location - C	City or Town, State
Balti	permit. Departm Importe any inju		21. Signature of Funeral Service Linense		2	2. Name and Ad	dress of Facility	HINES-RINA	LDI FUNE	CRAL HOME, INC. SPRING, MD 2090
8/60,	The law requires that the death certificate be executed a page 2 should be detached for use as the burial-transit	dicai Examiner	Shock of heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as a co	onsequence of):	CARDIO	VASCULAR	DISEASE		Interval Between Onset and Death
P.O. Box 6	the death certific y the attending p ched for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ Wo 9 □ Unknown	3c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	⊒Ectopic pregna ⊒ Other (specify		1, 11, 11	23d. Date Mont	of delivery th Day Year
	w requires that the de been signed by the a should be detached f	b	Part II. Dther significant conditions cor	ntributing to death but no	ot resulting in the u	Inderlying cause	given in Part I,			bute to the cause of death?  3 Probably 4 Unknown
al Records,		Completed						24a. Was autor perto 1 🗌 Yes	osy pr rmed? de	fere autopsy findings available for to completion of cause of path? Yes 2 \( \text{No} \)
DIVISION OF VITAL	uling Phye	ation: To Be	25. Was case referred to medical examiner?  1 XYes 2 No  27. Manner of Death  1 XNatural 5 Pending investigation	lospital: 1 Inpatient 28a. Date of Injury (Month, Day Ye	2 ER/Outpatie 28b. Time of Injury	of 28c. In	Other			· · · · · ·
DIVIS	tet or Attendl s after death. el Director: A ed in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (S	At home, farm, st Specify)	reet, factory, offi	се	28f. Location (S City or Tov	Street and Number vn, State)	r or Rural Route Number,
	To the Hospitei within 24 hours a To the Funerel I completely filled	edical	29a. Certifier (Check only one) 2 Medical Exami	sician: To the best of m ner: On the basis of exa and manner stated	y knowledge, deal amination and/or in	th occurred at the	e time, date and p ny opinion, death o			
	To To Com	Σ	29b. Signature and title of certifier	(Ome)			ense number 015236		29d. Date signed April 29	(Month, Day, Year)
	Γ'		30. Name and address of person who co				11 Rockv	ille, Mary	land 2	20850
	Sta Registr		31. Date filed (Month, Day, Year)  MAY 0 2 2005	2. Registrar's				·		

			1 - For State Registrar	State of N	laryland .	-	artment rtificate					jiene	05	164	26
Я	Physic	ian	Decedent's Name (First, Middle, I  CAT	Last) RY EUGENE 1	RDTCF				_		2. Date of Dea Month Dril	30,	2005	3. Time of I	
	/Medi Examir		4a. Facility Name (If not institution, g				4b. City, T	Town, or	Location of		.pr.rr		unty of Death	12:25	РМ
	Exami	101	Beverly Health (				Fred						derick		
	Funeral Director		216-38-0868	Sex 7. A 1 M 2 □ F	nge (In yrs. last 63	birthday) Yrs.	If Under 1 Months	1 Year Days	If Under Hours		Date of Birth (Month, Day an . 5,	1942	9. Birth Cou Mary	place (State or stry) Land	Foreign
	/land		Usual Residence of Decedent  10a. State 10b. County		10c. City, T	own or Lo	cation							10d. Inside City	y Limits
	e Man lifted	ctor	Maryland Frederi	ick	Thu	rmont	:							1 ₹ Yes	2 🗌 No
	with the	Director	10e. Street and Number 21 West Main Str	eet			10f. Zip (	Code 2178	38				of What Cou	ntry?	
	death	Funerai	11. Marital Status	12. Was Deceder	t Ever in U.S.	13. \	Was Decede			gin? (Speci	fy Yes or No- can, etc.)	14.	Race - Americ		
980	be filed within 72 hours after death with the Maryland tal Hygiene. Id other then "naturel; or Items 23e or 28e-1 ehow event, the Medical Examinar must be notified at	b	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces  1 ☐ Yes 2 ☐  If Yes, Give  Year or Dates	-No	- 1	t Yes, spect I □ Yes 2		Specify:		can, etc.)		Black, White, Bracify: Wh:	etc. Lte	
5-0	"natu	ietec	15. Decedent's (Specify only highest of	Education grade completed)	10	(Give	lent's Usual kind of work	done d	urina most	t of working		16b. Kind o	f Business/In	dustry	
Maryland 21215-0036	2 should be filed withir and Mental Hygiene. Ie marked other then aumatic event, the Ma	Completed	Elementary/Secondary (0-12)	College (1-4o	5+)		oondruse Luto P	,				NA	APA		
pu	be filed ital Hygie d other	Be	17. Father's Name (First, Middle, La						18. Mothe	r's Name (i	First, Middle,	Maiden Sun	name)		
ryla	should ind Men marke umatic	2	Chester Ray Bric			Ob Mailie	- 4 -				yn Fra				
	and 2 s ealth an n 27 le i er traus		Ann M. Fox (Frie								Route Number • Thuri				
Baltimore,	- I = E		20a. Method of Disposition 1 X Burial 2 □ Cremation 3	□Removal from State	20b. Place		sition (Name			Dat			on - City or To		
tim	permit. Pages Department of I Importent: If its Imy injury or o		`4 □ Donation 5 □ Other (Spec	cify)	Blue	4	e Cem		_	/4/05				aryland	
Bal	permit. Departr Importe any inju	[g ]	21. Signal of Fundal recollic	Chai	ley	RC   61	BERT 5 EAS	Addres E. I T MA	ATLE IN S'	Y & SO TREET	ON FUNI	ERAL H	HOMES, MD 217	P.A. '88	
	ann.		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final	mplications that each							espiratory arr	est,		Approximate Interval Betwo Onset and De	een
	/Medical		disease or condition resulting in death)	a Due to (or a	s a consequence		enea	ЛІС		on	ncer				
	Examiner	L	Sequentially list conditions,	b											
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events	Due to (or a	s a consequenc	ce of):									
o,	sate be executed physician and the burial-transit	Еха	resulting in death) Last	C Due to (or a	s a consequenc	ce of):									
8760,	cate be ohysici the bu	dicai		d		_									
Box 6	eath certific attending p for use as	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom								23d	Date of delive	ND/	
.O. B	at the death by the atte tached for	Physician/Me	in the past 12 months? 1 Yes 2 No 9 Unknown		2 Fetal dea at time of death		Ectopic pred Other (spec		. –				Month	Day Ye	ar
Vital Records, P	es tha igned be de	by	Part II. Other significant conditions	contributing to death	but not resulting	g in the ur	derlying cau	use giver	n in Part I.			oaccouseic es 2 □ No		ably 4 Un	
OOE	law requir as been s 2 should	pleted									24a. Was a		b. Were auto	psy findings av	vailable
E E	The ate h page	Compl									autops perforn 1 Yes 2	ned?	death?	npletion of cau 2□ No	ise of
	Physicien: Th this certificate al director, pag	o Be	25. Was case referred to medical examiner?	Hospital:				Other			Chack only on				
		$\vdash$	1 Yes 2 No 27. Manner of Death	1 ☐ Inpat 28a. Date of Inj (Month, D		Outpatient o. Time of		c. Injury	4 Nur		5 Reside			/)	
sior	Attending r death. sctor: After by the fune	catio	1 ☐ Matural 5 ☐ Pending 2 ☐ Accident investigati 3 ☐ Suicide 6 ☐ Could not	on	ay 70a7	Injury	М		es 2 🗆 N						
É		Certification:	4 Homicide determine	d 286. Place of Ir	ijury - At home, tc. <i>(Specify)</i>	farm, stre	et, factory,	office		28f	Location (St. City or Town		mber or Rura	l Route Numbe	∋Γ,
	To the Hospitel or within 24 hours afte To the Funerel Discompletely filled in	Medical C	29a. Certifier 1 Certifying F (Check only one)	Physician: To the bes aminer: On the basis and manner s	of examination	lge, death and/or inv	occurred at estigation, in	t the time	o, date and nion, deat	d place, and h occurred	due to the ca at the time, da	use(s) and ite and plac	manner as st	ated. the cause(s)	
	To the within 2 To the complet	Me	29b. Signature and tipe of certifier					License				_	ned (Month,	-	
)			Dried	W.	)		٠	P5	839	1		5-0	12-0	5	
	3		30. Name and address of person who	completed cause of $2/2, 100$ ,	801	TOS	el Ha	nus	e p	Ane.	Fre	deri	el , N.	S D217	701
State Registrar 31. Date filed (Month, Day, Year) 3 200 32. Registrar's Signature															

			For					lealth and M		giene	
			1 - State Registrar Amended		;FCHD	tm Cei	rtificate of	<b>Death</b> 05/3		Reg. No 2 0 1 5	16127
ı	Physici	an	Decedent's Name (First, Middle,						2. Date of De Month	15, 2005 Year	3. Time of Death
	/Media	al	William	Charles	Brand	it	[ a. =		April		10:10pM
4	Examir	er	4a. Facility Name (If not institution,					r Location of Death		4c. County of Deatl	
	Funeral		Frederick Mem 5. Social Security Number			ast birthday)	If Under 1 Year	derick	8. Date of Birt	Freder	
	Funeral Director		220-42-5313	1 <b>Ø</b> M 2□F	60	Yrs.	Months Days	Hours Min.	(Month, Da	y, Year) Co	nplace (State or Foreign untry) vland
	P .		Usual Residence of Decedent						TALITI :	7, 1945   Mal	yıanı
	arylar	_	Maryland 10b. County	rederick		, Town or Lo	sville				10d. Inside City Limits
	he M	Director	10e. Street and Number	Tedelick	<u> </u>						Yes 2 No
	with t	급		<b>.</b>			10f. Zip Code	0.0		10g. Citizen of What Co	•
	ns 23	Funeral	11. Marital Status	ton Ave.	t Ever in U.	S. 13. \	Vas Decedent of H	93 lispanic Origin? (Spe	acify Yes or No		ates
21215-0036	72 hours after death with the Maryland natural', or Items 23e or 28e-f ehow Jical Exartiret rust be notified at	by Fun	1 ☐ Never Married 2 ☑ Marrie 3 ☐ Widowed 4 ☐ Divorced	Armed Forces	? No		fYes, specify Cuba 1 □ Yes 2 ☑ No	Specify:	Rican, etc.)	Black, White Specify:	
2-0	72 hours "natural", alical Ext	ted	15. Decedent's	s Education	1	16a. Deced	lent's Usual Occup	ation		16b. Kind of Business/I	
218	- 1 19	Completed	(Specify only highest Elementary/Secondary (0-12)	College (1-4or	5+)	life. I	NOT use retired	during most of worki	ng		
2	D 70 =	Con		1		Pro	cessing l			U.S. Posta	l Service
and	b d la b	Be	17. Father's Name (First, Middle, L	ast)				18. Mother's Name	(First, Middle,	Maiden Sumame)	
Z	should be ind Mental i marked o umatic eve	70	Milton 19a. Informant's Name/Relationshi	- Cons. Drivel	Br	andt		Evely		Hartso	
Maryland	id 2 sho Ith and 27 Is m		Toni Brandt /	wife						er, City or Town, State, Z	
	1 ar Hea em		20a. Method of Disposition	wile	20b. PI	ace of Dispo	sition (Name of		alkers	ville, MD 2	
JOE L	0 0		1 ☐ Burial 2 ☑ Cremation : 4 ☐ Donation 5 ☐ Other (Spe		,  _		natory or other place. Cremato:	1	21 05	,	
Baltimore,	그 든 만 글		21. Signature of Funeral Service L		110		. Name and Addres			Frederick, Funeral Hom	
Ö	Depa Impo any ir		Raymond	Deler	in	) 4	0 Fulton	Ave. / Wa			21793
Г			23a. Part1. Enter the disease, or shock, or heart lailure. List o	omplications that cause nly one cause on each l	d the death	. Do not ente	ar the mode of dyin	g, such as cardiac c	r respiratory ar	rest,	Approximate Interval Between
H	Pnysician		Immediate Cause (Final disease or condition	9	Hen	atre	Fail	100			Onset and Death
	/Medical- Examiner		resulting in death)	Due to (or as	s a consequ	ience of):					
	- A	_	Sequentially list conditions, if any, leading to immediate	b. Due to (or as		Abuse	2				
	ted nsit	Examiner	Cause (Disease or injury	Due to (or as	s a consequ	ence or):					
	al-tra	xar	that initiated events resulting in death) Last	c Due to (or as	a consequ	ence of);					
68760,	icate be executed physician and s the burial-transit	edicat		d							
Вох	death certil e attending id for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1☐Live birth	2 ☐Fetal	death 3	Ectopic pregnancy			23d. Date of deliv	ery Day Year
P.O.	0 0 D	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□ Unknown	it time of de	ath 5	Other (specify)			World	Day 16ai
۵.	that the ed by detac		Part II. Other significant condition	s contributing to death I	but not resu	Iting in the ur	nderlying cause give	en in Part I.	23e. Did to	bacco use contribute to	the cause of death?
dŚ	law requires that the as been signed by th 2 should be detache	d by	Conquiant	hy Ane	nn	Res	·mbory	Zm Jus			bably 4 XUnknown
CO	w require s been sig should b	lete	J	( )				7	24a. Was	an 24b Were aut	opsy findings available
Vital Records	The lay	Completed							autop	sy prior to comed? death?	empletion of cause of
ital		BeC	25. Was case referred to medical					26. Place of Death		2⊠No 1 □ Yes	2 LJ N0
of <	Physic this ce al direc	ToE	examiner? 1 □ Yes 2☑ No	Hospital:	ent 2 E	R/Outpatien	3 DOA Othe	ar: 4 🗌 Nursing Hon	ne 5 Resid	lence 6 Other (Speci	fy)
.o 	ing Pl		27. Manner of Death  1 ☐ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ury ay Year)	28b. Time of Injury	28c. Injury Work	at 2	28d. Describe h	ow injury occurred	
sió	tend death tor: / the fi	cati	2 Accident investigat 3 Suicide 6 Could no	t be				Yes 2 □No			
Divisióń	Hospital or Attending Physicien: 44 hours after death as the remains after death is certific tell will be the funeral director, all tilled in by the funeral director,	Certification;	4 ☐ Homicide determin	ed 286. Place of In	tc. (Specify,	ne, farm, stre	et, lactory, office	4	City or Tow	itreet and Number or Rur m, State)	al Route Number,
_	spital ours neral filled		29a. Certifier † Certifying	Physician: To the best	of my know	viedge, death	occurred at the tim	ne date and place a	and due to the o	cause(s) and manner as s	rtated
	ne Ho 24 h se Fui	edical	(Check only 2 Medical E.	xeminer: On the basis of and manner st	of examinati	on and/or inv	estigation, in my op	pinion, death occurre	ed at the time, o	date and place, and due t	o the cause(s)
	To the Hospital or Attending Phys within 24 hours attended the Tothe Funeral Director: Aller this completely filled in by the funeral director and the funeral directors and the funeral d	M	29b. Signature and title of certifier				29c. License	number	2	29d. Date signed (Month,	Day, Year)
	X		Kenne	I and	<u>_</u> ,	N.O	. MIDD	0061175	2	4-16-0	5
	·\		30. Name and address of person w	no completed cause of	death (Item	23a) (Type, I					
			COXXIE L	7NN -12	cobs		trels,	2k /fz.	patrol	/ Frederic	K, rm 21/U1
<b>1</b>	Sta Registr		31. Date filed (Month, Day, Year)	32. Ry efisti	rar's Signati	ure	for of		V		
	riogioti	- k			A 4	-					

			1- For State of Maryland / Department / Department / Department / Department / Department / Depa	artment of Health and M rtificate of Death		71115 [51.90
		п	Registrar  1. Decedent's Name (First, Middle, Last)	Tillicate of Death	Reg. No	3. Time of Death
	Physici /Medic		Dorothy Florence Brensinger		May 1, 200	y Year
).	Examir	ięr <sup>*</sup>	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		. County of Death
16		V	10593 Willetts Crossing Road  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	White Plains If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	Charles  9. Birthplace (State or Foreign
	Funeral Director		577-22-6776 1□M 2X□F 83 Yrs.	Months Days Hours Min.	(Month, Day, Year)	1922 Washington DC
	pu >		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Lo			
	Aaryla F shov	ō				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	the N	Director	Maryland Charles Whit	e Plains 10f. Zip Code	10g Cit	tizen of What Country?
	h with	i Di	10593 Willetts Crossing Road	20695	103.0.	USA
	ems aria	Funerai		Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto F	ecify Yes or No-	14. Race - American Indian,
36	s after, or It	by Fu	1 Never Married 2 Married 1 Yes 2 No	1 ☐ Yes 2 No Specify:	ricali, etc.)	Black, White, etc.  Specify: White
Ö	tural'		3 XWidowed 4 □ Divorced Year or Dates:  15. Decedent's Education 16a. Decedent	dent's Usual Occupation	16h K	Specify: White
215	within 72 hours after death with the Maryland ene. than "netural", or Items 23s or 28s-1 show Its Medical Exist'illian is ust be neithfied at	piet	(Specify only highest grade completed) (Give	kind of work done during most of workir DO NOT use retired)	ng lob. K	and of businessymoustry
2	filed wit Hygiene other the	Completed	12 Tele	phone Operator	\$.B.	C. Phone Company
Maryland 21215-0036	d tal	Be	17. Father's Name (First, Middle, Last)		(First, Middle, Maiden	,
Ž	should and Men s marke umatic	To	George H. Sweet  19a. Informant's Name/Relationship (Type, Print)  19b. Mailir	ng Address (Street and Number or Rura	etta Parke	
<u>B</u>	and 2 sho ealth and n 27 is m		1 1 1 1	Willetts Crossing		
Jre,	of Health of Health itam 27		20a. Method of Disposition 20b. Place of Dispo			ocation - City or Town, State
Ē	Page ment c ant: If ury or		La bunar 2 Cremation 3 Linemoval from State	11 Cemetery   5-6-0	5 Suit	land, MD
Baltimore,	permit. Pages 1 an Department of Heali Important: If itam 2 any injury or other ance.			2. Name and Address of Facility  ntt Funeral Home		
	2		23a. Part1. Enter the disease, or complications that caused the death. Do not ent	O. Box 156, Waldo		04-0156 Approximate
	Physician		shock, or heart failure. List only one cause on each line.			Interval Between
	/Medical		disease or condition resulting in death)  a. Due to (or as a consequence of):	clerofic Carry	11007100090	Chicaro gosta
ū	Examiner	_	Sequentially list conditions, b.			
	rted nsit	mine	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury			
o î	execu an and rial-tra	Examiner	that initiated events c. Due to (or as a consequence of):			
8760,	cate be executed physician and the burial-transit	dicai	d			
9 XO	eath certific attending p for use as i	/Mec	IF FEMALE:			
Bo	The law requires that the death certific te has been signed by the attending p age 2 should be detached for use as	Physician/Me	III the past 12 highlitis:	Ectopic pregnancy Other (specify)	1	23d. Date of delivery Month Day Year
<u>о</u> .	that the de led by the a detached f	hysi	1   Yes 2   ZNo			
	es tha igned be del	ру Р	Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I.	23e. Did tobacco L	use contribute to the cause of death?
ord	w requir been si should				1 🗆 Yes 2 [	□ No 3 □ Probably 4 □Unknown
Records,	has b	ompieted			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
		O	or Western Control		performed? 1 ☐ Yes 2 ☑ No	death? 1 Yes 2 No
Vital	Physicien: this certific	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien	26. Place of Death	(Check only one)  ne 5 Residence (	0.5700
O		T:U	27. Manner of Death 28a. Date of Injury 28b. Time of		8d. Describe how injur	
SIOI	Attanding r death. actor: After y the fune	satic	2 Accident investigation	M 1 Yes 2 No		
Division	I or Attan after deatl Diractor: In by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury · At home, farm, strue building, etc. (Specify)	eet, factory, office	8f. Location (Street an City or Town, State	d Number or Rural Route Number, )
_	a Hospital or At 124 hours after o E Funaral Dirac letely filled in by	a C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death	occurred at the time, date and place, a	nd due to the cause(s)	and manner as stated
	To tha Hospital or Ai within 24 hours after of To the Funaral Dirac completely filled in by	edical	(Check only 2 Medical Examiner: On the basis of examination and/or invaries)	estigation, in my opinion, death occurred	d at the time, date and	place, and due to the cause(s)
	To the within 2 To the complete	Σ	29b. Signature and title of certifier	29c License number	29d. Dat	e signed (Month, Day, Year)
				18471	13/	400
1	Bd		30 Name and address of person who completed cause of death (Item 23a) (Type, I	Print) RI#11B 7	9 11/shu	y 10~ MD 20144
	Sta	te	31. Date filed (Month, Day, Year)  MAY 0 3 2005	1-10	1,001	110
	Registr	ar	MAY 0 3 2005	gove		

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day **EDWARD** BARNHART 29, A. M APRIL 2005 6:30 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death DEVLIN MANOR NURSING HOME CUMBERLAND ALLEGANY 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Months 1727 M 2□ F Director 77 YES. 212-24-0919 WEST VIRGINIA 19,1928 Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10b. County ?7 is markad other than "natural", or Items 23a or 28a-f show traumatic evant, the Modical Experimer must be notified at 10d. Inside City Limits Director 1 ¥ Yes 2 □ No MD ALLEGANY CUMBERLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 135 N. MECHANIC STREET, APT. #803 21502 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ Specify: 3 Widowed 4 Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) MACHINIST UNKNOWN RAILROAD 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be fi and Mental F is markad of JOSEPH WALTER BARNHART ပ ELVA ECKSHAW 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 s if Health an VERON BARNHART / WIFE 135 N. MECHANIC ST., APT.803, CUMBERLAND, MD 21502 20a. Method of Disposition

X□ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ita any injury or ot \* 4 ☐ Donation 5 ☐ Other (Specify) HILLCREST MEM1.PARK 05/02/2005 CUMBERLAND, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility UPCHURCH FUNERAL HOME, P.A. 202 GREENE STREET, CUMBERLAND, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <del>21520</del> 21502 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician /Medical Due to (or as a consequence of): Examiner atternation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? 2 No 1 ☐ Yes Hospital or Attanding Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 <del>☐ No</del> Other: Certification; To 4☐Nursing Home 5☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident hours after deatl unaral Diractor; 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ò 4 - Homicide determined within 24 hours at To tha Funaral D completely filled in 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0017565 DIVA 2, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

Laban

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Registrar's Signature

AJIZILIAC

2005

31. Date filed (Month)

			For State Registrer		State of	Marylar		artmeni rtificate				ental Hy	giene Reg. No		16431
	Dharaia		1. Decedent's Name (First	Middle, Las	t)							2. Date of Do	aath		3. Time of Death
	Physic /Medi		Elizab			Christin	ıa	В1	ank			April	26, Da	2005 Year	0420 A M
	Exami	ner	4a. Facility Name (If not in:	stitution, give	street and num	ber)		4b. City,	Town, or	Location of	of Death		4c	. County of Deat	h
			Frostburg Vi 5. Social Security Number	Llage No		re Cente 7. Age (In yrs.		If Under	rosth	urg If Under	24 Hrs	B. Data at Bi	45	Allegar	
	Funeral Director		215-36-9465		M 2∏F	94	Yrs.	Months	Days	Hours	Min.	8. Date of Bi (Month, Di 08/21/	ay, Year)	Co	hplace (State or Foreign untry)
	_		Usual Residence of Deced									08/21/	[910]	Mar	yland
	show	_	10a. State 10b. 0	County		10c. Ci	ty, Town or Lo								10d. Inside City Limits
	he M.	Director		Alle	gany		- Ka	wlings							1 ☐ Yes 2 No
	with	급	10e. Street and Number 15903 M	iller A	707110			10f. Zip	Code	21557			_	tizen of What Co SA	untry?
	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show ha Medical Examinar matter colified at	Funeral	11. Marital Status	TILE! A	12. Was Deced	dent Ever in U	I.S. 13.	Was Deced	ent of Hi		gin? (Spe	cify Yes or No		5A 14. Race - Ame	ncan Indian
9	after o	臣	1 Never Married 2	Married	Armed Ford	ces? 2.t⊽lNo						cify Yes or No Rican, etc.)		Black, White	e, etc.
21215-0036	ours iral', c	d by	3XXWidowed 4 □ Di	vorced	If Yes, Give Year or Da	•		1 □ Yes 2	No LX	Specify:				Specify:	White
5	natu adica	Completed	15. De (Specify only	cedent's Ed highest grad	ucation de <i>completed)</i>		(Give	dent's Usua kind of wor	k done d	urina mos	t of workir	ng	16b. K	ind of Business/l	ndustry
12	withir ene. then	ш	Elementary/Secondary (	0-12)	College (1-	4or 5+)	life.	DO NOT us	e <i>retired)</i> Homen				п	omamal. a.s.	
d 2	fited within Hygiene. other then ant, the M		17. Father's Name (First, A	fiddle, Last)	· ·						r's Name	(First, Middle		omemaker	
Maryland	d ta b >	To Be	John		Lewis		Beal			Laur			oecca		Albright
ary	2 should and Men is marke aumatic	_	19a. Informant's Name/Re	lationship (T	ype, Print)		19b. Mailir	ng Address	(Street a	n <b>d</b> Numbe	or Or Rura	i Route Numb	er, City o	or Town, State, Z	lip Code)
	1 and 2 Health am 27 I		Leonard K. Blan	nk / son	1		_				awling	s, Mary	Land	21557	
Baltimore,	permit. Pages 1 and Department of Health Important: If itam 27 any injury or other tr	1.3	20a. Method of Disposition 1	ation 3 □	Removal from S	tate 20b. F	Place of Dispo cemetery, crer	sition (Nam natory or ot	e of her place	)	D	ate	20c. Lo	ocation - City or 1	Fown, State
턡	permit. Pages. Department of the Important: If its any injury or of guille.		`4 □Donation 5 □O	her (Specify	)		Savage				4/29/	2005	Mt.	. Savage.	MD
Bal	Depar Depar Impor any in		21. Signature of Filneral S	ervice Licens	500		22							neral Home	
			23a. Part1. Enter the dise	se or comp	dications that car	used the deat	b. Do not ont							ryland 21	Approximate
	The law requires that the death certificate be executed By Manager 2 should be detached for use as the burial-transit	dical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions if any, leading to immediat cause. Enter Inderlying Cause (Disease or injury that initiated events resulting in death) Last	<b>\</b>	b. Due to (o	r as a consequence as a	uence of):  United the second of the second	AR	TERL		(2 ISEA	SJ2		A	hut years
× 68	entificat ding phy se as th	/Medi	IF FEMALE:		23c. If yes, outco										
.O. Box	at the death certific by the attending p tached for use as	Physician/Me	23b. Was decedent pregna in the past 12 months 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1111	1□Live bir	th 2□Feta nt at time of d	I death 3	Ectopic pre Other (spe						23d. Date of deliv Month	very Day Year
σ.	s that ned b s deta	by Pt	Part II. Other significant c	onditions co	ntributing to dea	th but not res	ulting in the ur	nderlying ca	use give	n in Part I.		23e. Did t	obacco u	use contribute to	the cause of death?
rds	quires nn sign uld be	d be	CLA	onic	ORSTA	weTI	VE C	uno	= 1h	\$52M3	ry:	1 🗆 '	res 2	□No 3□Pro	bably a Unknown
Vital Records,	law requir is been si 2 should	Completed										24a. Was		24b. Were aut	opsy findings available
ž	The I	mo										autor perfo	osy rmed? 2 <b>⊊</b> No	death?	ompletion of cause of
ita/	sician: 1 certifical rector, p	Be	25. Was case referred to mexaminer?	<u> </u>						26. Place	of Death	(Check only o			
of \	Physician: this certific al director,	은	1 ☐ Yes 2 ☐ No				ER/Outpatien		100	4LXNUI	rsing Hom	ie 5 ☐ Resi	dence (	6 □Other (Speci	ify)
		Certification:		ending	28a. Date of (Month,	Injury Day Year)	28b. Time of Injury		c. Injury Work	?		8d. Describe I	now injur	y occurred	
Division	ten for: the	licat	3 ☐ Suicide 6 ☐ 0	ould not be	28e Place o	f Injuny - At he	ome, farm, stre	M		es 2□N		9f Location (	Stroot on	d Number of Pur	al Route Number,
É	after date displaying by 1	ertil	4 Homicide	letermined	building	g, etc. (Specify	y)	set, factory,	OHICO		-	City or To			ar noute ivamper,
	To the Hospital or At within 24 hours after of To the Funeral Dirac completely filled in by	ledical C	29a. Certifier 1 X Ce (Check only 2 Me	rtifying Phy dical Exami	sician: To the biner: On the bas	is of examina	wledge, death tion and/or inv	occurred a estigation,	t the time	e, date and nion, deat	d place, ai h occurre	nd due to the d at the time,	cause(s) date and	and manner as place, and due t	stated. to the cause(s)
	To the twithin 2. To the Complet	Me	29b. Signature and title of	ertifier				29c.	License	number			29d. Dat	e signed (Month,	Day, Year)
i	1		•	27	tells				D269	07			Apri	1 26, 200	5
	has		30. Name and address of p	erson who co	ompleted cause		op Walsh		, Cum	berlan	ıd, Ma	ryland	21502	2	
		te	31. Date filed (Month, Day,	Year)	1.4	jistrar's Signa						3			
	State 31. Date filed (Month, Day, Year) 32. Registrar's Signature APR 2 6 2005														

Amended #17, nls, Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 05/03/05, Allegany Co. State of Maryland / Department of Health and Mental Hygiene For Stete Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Allen Buskirk Irvin 1245 29 05 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death St Vincent de Paul Allegany Frostburg, md
If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) 12 M 2□ F 215-16-4263 Director SO Yrs. Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "netural", or items 23a or 28a-f show other treumstic avent, the Mudical Examinat must be notified at Director Maryland 1 ☐ Yes 2 XNo Allegany Frostburg 10e. Street and Number 19911 Woodland Road, S.W. 10g. Citizen of What Country? 10f. Zip Code 21532-U.S.A Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2X Married 1 Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 Specify: White 1 Yes 22 No Specify: permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "netural", eny injury or other treumatic avent, Ite Medical Eva once. 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6 driver truck union 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Paul Leonard Aldridge Unknown Jesse V. Buskirk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19911 Woodland Road, Virginia Buskirk wife Frostburg Maryland 21532 20b. Place of bisposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State `4 ☐ Donation 5 ☐ Other (Specify) Frostburg Memorial Park 02-May-2005 Frostburg 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final SBSTRUCTIVE LUNC DISPERSE **Physician** disease or condition resulting in death) CHRONIC /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): The law requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ARTERY 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed certificate has b irector, page 2 sl 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Division of Vital 1 ☐ Yes 2 🔀 No To the Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Sursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No this 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? After 1 Natural 2 Accident 5 Pending after death. investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 126907 APRIL 29, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

nLs

Sidhu

3 Registrar's Signature

M.D., 925 Bishop Walsh Kd, Cumberland, Maryland 21502

amend Item#3, perMD, G845, // Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 30, Day Year Fanny Combs 10:05 AM 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 607 Crestview Lane Salisbury Wicomico 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months 1 □ M 2 🔀 F Days Hours 101-30-0442 10/17/1907 Germany Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☑ Yes 2 ☐ No Maryland Wicomico Salisbury 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 607 Crestview Lane 21801 USA 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2K No Specify: Specify: 3 XWidowed 4 ☐ Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 caterer catering 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Josef Neuberger Johanna Geiger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William A. Combs/son 607 Crestview Lane, Salisbury, MD 21801 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Trinity Church Yard \* 4 ☐ Donation 5 ☐ Other (Specify) 5/5/05 Hewlett, NY Cemetery manure of Funeral 9 ervice Ligensee 2. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Parh, Enter the disease, or complications that caused the ospock, or heart failure. List only one cause on each line. eeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final FAILURE disease or condition resulting in death) montHS Due to (or as a consequence of). ULCEA Co RoNAR y CEREBRAL VASCULAR ACCIDENT

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permit. Pages 1 and 2 should be Department of Health and Mental Importent: If item 27 is marked of any injury or other traumatic ≈ve

Baltimore, Maryland 21215-0036

Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Year

IF FEMALE: 23b. Was decedent pregnant

in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 Pregnant at time of death

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month Day

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

9 Unknown

DERTENSION SENILE

DEMENTIA DEGENERATIUS

DISEASE TOINT 26. Place of Death Check only one)

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a Was an autopsy performed 2 No 1□ Yes

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of

28c. Injury at Work?

Other: 4 Nursing Home 5 Presidence 6 Other (Specify)

28d. Describe how injury occurred

1 Natural 2 Accident investigation 6 ☐ Could not be 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of dertifie

5 Pending

29c. License number H GO 48241 29d. Date signed (Mopth, Day, Year)

2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

540 RIVEASIDE DR. #6, SAUSBURY, MD 21801

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State Registra

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E.

trar's Signature Registrar's Sign

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month **Physician** Yea WILLIAM E. CLARK A /Medical 05 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SALISBURY WICOMICO HOSPICE ATTHE LAKE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, JUNE 20, 9. Birthplace (State or Foreign Funeral Days , Year) 1918 1 XM 2 F Hours 165-14-6164 86 Yrs. PENNSYLVANIA Director Usual Residence of Decedent death with the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, in a Modical Examinar must be notified at Director 1 ☐ Yes 2 X No BERLIN WORCESTER BERLIN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1070 OCEAN PARKWAY 21811 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 (X)Yes 2 □ No If Yes, Give Year or Dates: 1942-45 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Š Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) REPAIRMAN VENDING MACHINES 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be f nent of Health and Mental I ant: If item 27 Is marked of WILLIAM CLARK ဂ္ SR. TDA EVERLINE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DOROTHY CLARK/WIFE 1070 OCEAN PARKWAY, BERLIN, MARYLAND 21811 item 27 other t 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State = 5 Department of Important: If any injury or once. 4/29/05 4 ☐ Donation 5 ☐ Other (Specify) HILLSIDE CEMETERY ROSLYN, PENNSYLVANIA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 afree 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Filysician disease or condition resulting in death) /Medical Due to (or is a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Unitaritying Cause (Disease or injury Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medicai JE FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year 4☐Pregnant at time of death Day 5 Other (specify) Division of Vital Records, P.O. the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ filled in by the funeral director, page 2 should be 3 ☐ Probably 4 ☐ Unknown 1 Tyes 2 **⊅**No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 0 1 Yes 1 🗌 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 1 Div atient Certification: To 1 🗌 Yes 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of eath 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of After ! 28d. Describe how injury occurred 5 Pending after death. death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide within 24 hours a To the Funeral D 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) To the 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CONALL Date filed (Month, Day, Year) State APR 2 9 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. U Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year APRIL **Physician** EARL COLE LESTER 2005 30 7:00 A /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner MONTGOMERY DAMASCUS Under 1 Year | If Under 24 Hrs. 9813 MOYER ROAD 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours Min. Months 1 M 2 □ F 212-38-3570 62 Director June 4 1942 Virginia Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or Items 23s or 28e-f show the Medical Examiner must be notified at 1 Yes 2 No Montgomery Damascus Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20872 9813 Moyer Road United States death Funera Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Itel injury or other treumatic event, the Mudical Event and 1 ☐ Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Construction 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Earl Cole Dorothy Wanda 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gayle L. Cole / Wife 9813 Moyer Road, Damascus, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 5/04/05 Germantown Baptist Germantown, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Muriel H. Barber Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. mornis Approximate Interval Between Onset and Death Immediate Cause (Final DITATZATEM **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 2 Fetal death 3 Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 9☐ Unknown 5 Other (specify) 2 No the 9 Unknown been signed by should be detac 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? has page 2 certificate 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) No 2 1 Tes 2 ER/Outpatient 3 DOA After this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: the Hospitel or Attending 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide To the Funerel 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature D35635 completed cause of death (Item 23a) (Type, Print 30. Name and address of person who Prince 18111 OLNE KM JOSEPH

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

0 2 2005

2. Registrar's Signature

			1 - For State Registrar	State of M	aryland / Dep <i>Ce</i>	artment of F			giene () ()	15 16436
	Discrete:		1. Decedent's Name (First, Middle, La	st)				2. Date of Dea	ath	3. Time of Death
	Physici /Media		Charles A	lbert	Chamber	lin		April 2	4, 2005	12:44a <sup>M</sup>
	Examir		4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town, or	r Location of Deati	า	4c. County of	of Death
			Suburban Hospita	1	de la	Bethes	If Under 24 Hrs.		Monts	9. Birthplace (State or Foreign
	Funeral Director		5. Social Security Number 6. S <b>009 14 4601</b>	M 2□F	ge (In yrs. last birthday, Yrs.	Months Days	Hours Min.	(Month, Da	h y, Year) 1926	
			Usuel Residence of Decedent		,,			Dec ZZ	, 1920	Vermont
	how		10a. State 10b. County	-	10c. City, Town or L	ocation				10d. Inside City Limits
	e Ma	cto	Maryland Montgon	nery	Burton	sville				1 ☐ Yes 2/DXNo
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	s 23s	- La	3200 Greencastle		5 110 10		0866		11.5	USA
	72 hours after death with the Maryland natural; or Items 23a or 28a-f show iteal Examinar must be notified at	Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Armed Forces? 1 □ Yes 2 🛣	Ever in U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (S an, Mexican, Puert	pecify Yes or No- o Rican, etc.)	Black	e - American Indian, k, White, etc.
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<b>∑</b>	d 2 si th an t7 is r traur	7							71001 1000	re on our owners
	ss 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at		Gregory C. Chamber 20a. Method of Disposition	eriin / So	120b. Place of Dispe	osition (Name of		Burtons Date	20c. Location - 0	city or Town, State
о П			1 □ Cremation 3 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif		Union Co	matory or other place emetery		0/2005	Ruttonev	ville, Maryland
Baltimore,	교본문동		21. Signature of Funeral Syrvice Ucer	1		2. Name and Addres				
Ö	Depar Impor any ir		+ Some Ky	lech	1:	1800 New 1	Hampshire	e Ave Si	lver Spr	ing, MD 20904
			23a. Pert1. Enter the disease, or com sheck, or heart failure. List only	plications that caused one cause on each li	d the death. Do not en	ter the mode of dyin	g, such as cardiad	or respiratory ar	rest,	Approximate Interval Between
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	/Medical		resulting in death)	Due to (or as	a consequence of):					3 Months
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	sit sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or Injury	Due to (or as	a consequence of):					
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	ficate g phys	edicai		. d						
Вох	leath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		7			23d. Date	of delivery
m .	death	icia	in the past 12 months? 1 Yes 2 No	4 ☐ Pregnant at		∃Ectopic pregnancy ∃Other ( <i>specify</i> )			Mont	th Day Year
P.0	at the de by the a stached i	hys	9 Unknown	9□ Unknown						
S,	The law requires that the death certif te has been signed by the attending age 2 should be detached for use as	by F	Part II. Other significant conditions of			inderlying cause give	en in Part I.	23e. Did to	_	bute to the cause of death?
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	(0 LT	So						perfor		eath? □ Yes 2 □ No
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Othe	00	th (Check only or		
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CO	ding F h. After funer	tion	1 Natural 5 ☐ Pending	(Month, Da	y Year) Injury	Worl	Yes 2 □ No	20d. Describe II	OW HIJDLY OCCUITE	9
Division	or Attendi after death. Diractor: A in by the fu	fica	3 Suicide 6 Could not be	28e. Place of Inj	jury - At home, farm, st			28f. Location (S	treet and Number	r or Rural Route Number,
á	spital or A ours after saral Dirac filled in by	Certification:	4 Homicide	building, et	ic."(Specify)			City or Tow	n, State)	
	To the Hospital or Attending within 24 hours after death. To tha Funaral Diractor: After completely filled in by the fune		29a. Certifier Check only 2 Medical Exam	ysician: To the best	of my knowledge, deat	h occurred at the tim	ne, date and place	, and due to the o	ause(s) and man	ner as stated.
	To the Hos within 24 h To the Fur completely	edical	one) 2 Medical Exam	and manner st	f examination and/or in ated.	vestigation, in my or	pinion, death occu	rred at the time, o	late and place, ar	nd due to the cause(s)
	To the To the comple	Σ	29b. Signature and title of certifier	1.1/N s	n COM in	29c. License		á		(Month, Day, Year)
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			30. Name and address of person who							/
			Frederick W. Ran 31. Date filed (Month, Day, Year)		1-01-		own Road	Bethese	la, Mary	land 20814
80	Sta Registi	- 1	MAY 0 2 20	05 Kedene	ars Signature	Me				

Chamberlian, Charlie 4/24/05

			1- For State of Maryland / Dep Registrar Ce	artment of Health and Mertificate of Death		ene 0 0 5	16437
			1. Decedent's Name (First, Middle, Last)		2. Date of Death	Day Year	3. Time of Death
н	Physicia /Medic		Karolin Ann Bratkowski Cheboski		Month April	30, 2005	0003 A <sup>M</sup>
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deat	h
			Casey House	Rockville		Montgome	ry
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	Months Days Hours Min.	8. Date of Birth (Month, Day,	Year) Co.	nplace (State or Foreign untry)
	Director		491-50-9983		Nov 16,	1946 Mis	souri
	and *		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Li	ocation			10d. Inside City Limits
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	28a-	Director	Maryland Montgomery N. Bethes	10f. Zip Code	10	g. Citizen of What Co	untry?
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	eath	Funeral		Was Decedent of Hispanic Origin? (Spec		14. Race - Ame	rican Indian,
<b>,</b>	r Iten	E	Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 1 □ No	If Yes, specify Cuban, Mexican, Puerto F	lican, etc.)	Black, White	e, etc.
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Maryland 21215-0036	s 1 and 2 should t f Health and Ment item 27 is marked other traumatic	0.04		ing Address (Street and Number or Rural		-	
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Baltimore,	permit. Pages Department of b important: If Ite any injury or of once.			2 Name and Address of Facility Soing Home Crematio Severly L. Heckrott			
	-		23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac or	respiratory arre	st,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition a. Abdominal Sarcoma				Onset and Death
	/Medical		resulting in death)  a. ADUOIIITIAL SALCOIIIA  Due to (or as a consequence of):				
١.	Examiner		Sequentially list conditions				
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0,	e exe ian a urial-		resulting in death) Last Due to (or as a consequence of):			I	
8760,	death certificate be executed e attending physician and nd for use as the burial-transit	Physician/Medical	d				
9	ntifica ing pl	Mec	IF FEMALE:				
Вох	eath certific attending p	lan/	23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3	□Ectopic pregnancy		23d. Date of deli	very Day Year
	the a	sic	1 ☐ Yes 2 No 9 ☐ Unknown 9 ☐ Unknown	Other (specify)			,
P.O	w requires that the dibean signed by the should be detached	Phy	Part II. Other significant conditions contributing to death but not resulting in the	underkring equate groon in Part 1	23a Did tob	acco use contribute to	the cause of death?
ls,	ires ti signe	by	Tall II. Office significant conditions contributing to death but not resulting in the	andonying oddoo giroiriiri ditii.	1 ☐ Yes		
orc	neen s	ompleted			, , , ,	Λ	
ec	2 2 3	nple			24a. Was an autopsy	prior to d	topsy findings available completion of cause of
=	Th ate pag	Co			perform 1 Yes 2	ed? death? ∑No 1 ☐ Yes	2 No
Vital Records,	Physician: this certific ral director.	Be	25. Was case referred to medical examiner?	26. Place of Death			
of	Physic this cal dir	2	1 Yes 2 No			nce 6 XOther (Spec winjury occurred	nospice
		lon	27. Manner of Death  1X\ Natural 5 \ Pending \ Pending \ (Month, Day Year) \ Injury	Work?	ad. Describe nov	w injury occurred	
Sic		cat	2 Accident investigation 3 Suicide 6 Could not be 280 Place of Injury At home large st	M 1 Yes 2 No	91 Location (Str	eet and Number or Ru	ral Paula Number
Division	or Atten efter deat Director: in by the	Certification;	4 Homicide determined 28e. Place of Injury - At home, larm, st building, etc. (Specify)	reet, lactory, office	City or Town,		rai Houle Number,
	To the Hospital or within 24 hours efter To the Funeral Director Completely filled in b		29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea	th assured at the time date and alars -	nd due to the co	use(s) and manner	stated
	Hos 24 hc Fun stely	Medical	(Check only 2 Medical Examiner: On the basis of examination and/or in and manner stated.				
	To the within 2 To the comple	Mec	29b. Signa ure and little of certifile	29c. License number	29	d. Date signed (Month	n, Day, Year)
	F 3 F ŏ		MI WIN	D35635	Δ1	oril 30, 2	005
			30. Name and address of person who completed cause ol death (Item 23a) (Type		11		
$(\Xi)_0$	3		Joseph Kaplan M.D. 6001 Muncaster Mil		D 20855		
	Sta	ite	31. Date filed (Month, Day, Year) 32. Pogistrar's Signature				
	Registr		MAY 0 3 2005 Status &	barke			

KAROLIN CHEBOSKI

		1 - For State Registrar	State of M	arylan		artment of He		nd Menta		900	E 10100
		Registrar     Decedent's Name (First, Middle)	, Last)		001	inoate of L	Call		ate of Death	. No	3. Time of Death
Physicia		Milo	Cline					May	y 1,	2005 Y	11:30 A M
/Medic Examin		4a. Facility Name (If not institution				4b. City, Town, or	Location of	f Death		4c. County of	Death
		8701 Artie	Kemp Road			Frederic				Freder	
Funeral		5. Social Security Number 215–36–7065	6. Sex 7. Ag	ge (In yrs. <b>87</b>	last birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min (M	ate of Birth fonth, Day, Y	(ear) 9	Birthplace (State or Foreign Country)
Director		Usual Residence of Decedent	,-	07	110.			Apr	11 11,	1918 M	агутапо
yland	1	10a. State 10b. County		10c. Cit	y, Town or Lo	cation					10d. Inside City Limits
e Mar	ctor	Maryland Frede	rick	Fre	derick						1 □ Yes 2 No
or 26	Directo	10e. Street and Number	Dood			10f. Zip Code 21701			"	. Citizen of What U.S.A.	it Country?
If it is in the Maryland flied within the Maryland Hygiene. Hygiene Than "natural; or items 23a or 28a-f show ant, It whe life I is in er must be nailified at	eral	8701 Artie Kemp	12. Was Decedent	Ever in U	S 13 V	Vas Decedent of His	spanic Orio	in? (Specify Y			American Indian,
fter de r ttem inerr	Funeral	11. Marital Status  1 □ Never Married 2 Marr	Armed Forces? ned 1 ☐ Yes 2 🛣	?	'	f Yes, specify Cubar	n, Mexican	, Puerto Rican,	, etc.)	Black,	White, etc.
urs at	ρ	3 Widowed 4 Divorced	If Yes, Give			1 ☐ Yes 2 🔯 No	Specify:			Specify:	white
72 ho	Completed	15. Deceden (Specify only highes	i's Education		(Give	ient's Usual Occupa kind of work done d	uring most	of working	16	b. Kind of Busin	ess/Industry
vithin ne. han *	mpl	Elementary/Secondary (0-12)	College (1-4or	5+)		DO NOT use retired)	)			A	1
Hygie thar t		12 17. Father's Name (First, Middle,	Last)		Farme		18. Mothe	r's Name (First	t, Middle, Ma	Agricu iden Sumame)	ıture
d be d be sental	To Be	Charles R. Cl					Li11	y Cath	erine	Gladhi1	1
iges 1 and 2 should be filed within 72 hours after death with the Marylan to Health and Mental Hygiens.  If it health and Mental Hygiens.  If it it man 27 is anaked other then "natural, or items 23e or 28e-f show or other traumatic avant. It was beside a	-	19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailir	ng Address (Street a	nd Numbe	r or Rural Rout	te Number, C	City or Town, Sta	ite, Zip Code)
and 2 alth a 27 te		Louise Cline	Wife		_	Artie Kem					
es 1 a of He fitam		20a. Method of Disposition  1 ★ Burial 2 □ Cremation	3 □Removal from State			sition (Name of natory or other place		Date			y or Town, State
Page ment ant: I ury o		`4 Donation 5 Other (S	pecify)	Res		Memorial		5/5/200	5 F	rederic	k, Maryland
partificate, inc permit. Pages 1 and 2 Department of Health a Important: If itam 27 ta any injury or othar trat		21. Signature of Funeral Service	ille Ela	ine		2. Name and Addres 21 Opossu		o Lau.		uneral rick, M	Home aryland 21702
	ch.	23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cause only one cause on each I	d the deat line.	h. Do not ent	er the mode of dying	g, such as	cardiac or resp	piratory arres	t,	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	a (0	حے 6 سے	TIVE H	GORT KAILU	RE				Onset and Death
/Medical Examiner		resulting in death)	Due to (or as				_				,
	7.	Sequentially list conditions, if any, leading to immediate	b. Due to (or as			BRY DISEA	80				years
uted I Insit	Examiner	cause. Enter Underlying Cause (Disease or injury	<b>S</b>								
execting and ital-tra	Exa	that initiated events resulting in death) Last	Due to (or as	s a consec	quence of):						
ate be executed hysician and the burial-transit	cal		d								
w requires that the death certificate be executed wrequires that the death certificate be executed been signed by the attending physician and should be delached for use as the burial-transit	Physician/Med	IF FEMALE:								1	-
ath ce	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 Feta	al death 3□	Ectopic pregnancy				23d. Date of Month	,
the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□Unknown	it time or c	ieath 5	Other (specify)					
law requires that the as been signed by the 2 should be detached.	y Ph	Part II. Other significant condition	ons contributing to death	but not res	sulting in the u	nderlying cause give	en in Part I.	. 2	3e. Did toba	cco use contribi	ite Io the cause of death?
w requires been sign should be	d by		IABETES					_ 8	1 🗆 Yes	2 No 3	☐ Probably 4 ☐ Unknown
law rec as bee 2 shor	Completed							2	4a. Was an autopsy	24b. We	re autopsy findings available or to completion of cause of
- 0 - 2	E O							1	performe	ed? dea	th? Yes 2 No
VICIAN: The ician: The certificate ector, pag	Be C	25. Was case referred to medica examiner?	-					of Death (Che	ock only one)		
Or VILA Physician: rithis certific ral director,	2	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpati		ER/Outpatier	-	4 LINU	35 - 4	-	ce 6 ☐ Other	(Specify)
Jn G	lon:	27. Manner of Death 1   A Natural 5 □ Pendir		ay Year)	28b. Time of Injury	Work	rat ⟨? Yes 2. □ I		Describe now	injury occurred	
or Attending fiter death. Diractor: After in by the fune	ficat	2 Accident investi	not be 300 Place of In	njury - At h	ome, farm, str	reet, factory, office		28f. Le	ocation (Stre	et and Number	or Rural Route Number,
after after dinb	Certification:	4 Homicide	building, e	itc." (Speci	fy)			C	city or Town,	State)	
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,		29a. Certifier 1 Certifyin	ng Physician: To the besi Examiner: On the basis	t of my kn	owledge, deat	h occurred at the tim	ne, date an	d place, and di	ue to the cau	se(s) and mann	er as stated.
tha Hi in 24 tha Fi pletel	ledical	one)	and manner s		adon and/or in			ar occurred at			
To I To I	Σ	29b. Signature and title of certifie	"\\ ~~			29c. License	number	1	290		Month, Day, Year)
			VIV				, С 1 /	,		5/2/	01
6.		30. Name and address of person		-	m 23a) (Туре. Бою З		CALOR S	SUICLE	MD	21793	
Sta	ate	31. Date filed (Month, Pay, Year,	32. Recist	trar's Sign	ature_	1	21-01-0		-		
Regist		MAY U	3 2005	Conso	A A	Segral /					

			1 - For State Registrar	State of N	Marylar		artment of F				iene	2°14 8'994	
			1. Decedent's Name (First, Middle, Las	)					2	2. Date of Deatl	1 Can U	UÜ	3 Time of Death
	Physici /Medi		Charle	s Blaine	Crai	g, Sr.				Month April	Day 30, 2	Year 005	0115 M
	Examir		4a. Facility Name (If not institution, give	street and number	er)		4b. City, Town, or	r Location	of Death		4c. County	of Death	
			Harford Memoria	al Hospi	tal		Havr	e de	Grace			Harfo	ord
	Funeral		5. Social Security Number 6. Se	x 7.7		last birthday)	If Under 1 Year Months Days	If Under Hours	Min	Date of Birth	Year)	9. Birth	place (State or Foreign ntry) aryland
	Director		213 01-3731	M 2 1	86	Yrs.			Al	pril 17	,1919	Ma	aryland
	and		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation					1.	10d. Inside City Limits
	Mary f sh	ō	Maryland Ceci	1				ryvil	110				1 ☐ Yes 2 ☑ No
	28a	Director	10e. Street and Number				10f. Zip Code			10	g. Citizen of t	Albah Cau	
	38 O	i D	1729 Perryville H	Road			10000	2190	2			.S.A.	
	within 72 hours after death with the Maryland ene. than "neturel", or Items 23e or 28e-1 show ta Madical Examiner must be redilled at	Funeral	11. Marital Status	12. Was Deceder	nt Ever in U	.S. 13. V	Vas Decedent of Hi		-	fv Yes or No-			can Indian,
9	after or Ite	Ē	1 ☐ Never Married 2 ☒ Married	Armed Force:			Vas Decedent of Hi Yes, specify Cuba			can, etc.)		k, White,	
က္က	rel',	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates	s: WW I	II 1	☐ Yes 2⊠ No	Specify:			Specify	·: Wh	nite
21215-0036	72 h 'netu	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)			ent's Usual Occupa		t of working		6b. Kind of B		
2	nathin han "	idu	Elementary/Secondary (0-12)	College (1-4o	r 5+)	life. C	OO NOT use retired	)		V			Center
	filed w Hygiel other ti	S	Twelve Years				Shop For						Maryland
aryland	be fi	Be	17. Father's Name (First, Middle, Last)	D				18. Mothe	er's Name (F	irst, Middle, M	aiden Suman	10)	
3	should be nd Mental marked c	ပ		Bruce Cra	aig					Jane B			
<u>a</u>	0 6 6		19a. Informant's Name/Relationship (Ty				g Address (Street a						
e,	1 and 2 Health Iem 27 other tre		Ruth M. Craig (w	ife)	20h B		Perryvil	le Ro		_			
altimore,	Pages nent of h ant: If ite		1 ☑Burial 2 ☐ Cremation 3 ☐ F	emoval from Stat	е с	emetery, crem	ition (Name of atory or other place	´	Date		Oc. Location -	City or To	own, State
	rtmer rtant njury		' 4 □ Donation 5 □ Other (Specify)		Wes		gham Cemete		05/05/	/05 C	olora,	Mary	yland
Ba	permit. Pages 1 and Department of Heali Important: If item 2 any injury or other 2006.	d	21. Signature of Funeral Service Licens	) Julian		Le	Name and Addres e A. Patt rryville,	erso	n & Sc	n Fune:	ral Hor	ne, F	P.A.
	*		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	cations that cause	ed the death	. Do not ente	r the mode of dying	g, such as	cardiac or re	spiratory arres	t,	n	Approximate
	Pnysician		Immediate Cause (Final disease or condition	1		emon							Interval Between Onset and Death
	/Medical		resulting in death)	Due to (or a		ience of			^		_	-	lodan
	Examiner		Sequentially list conditions,		UTI	(Uni	rany Tr	aur	In	celtur		1	ENKS
	ed sit	iner	cause. Enter Underlying	Due to for a		ionice oi).	1		- (	,			2
(	ecute and trans	Examin	Cause (Disease or injury that initiated events resulting in death) Last			cenn	P						ZWKS
/60,	cate be executed physician and the burial-transit		rossiting in doddin Cast	Due to (or a	s a consequ	ience of):							
× ×	physic the k	dicai											
o ×		/Me	IF FEMALE:	20 If you system	4								1-11-
X Q Q	that the death certif ed by the attending detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome 1 ☐ Live birth	2 Fetal	death 3 🗆	Ectopic pregnancy				23d. Date Mor	of delive	ry Day Year
j	he de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□Unknown	at time of de	eath 5	Other (specify)				19101	ui	Day Feat
7.	requires that the een signed by th nould be detache		Part II. Other significant conditions con	tributing to death	but not resu	liting in the unc	tertying cause give	n in Part I	-	22a Did taha	200 1100 0004	busa sa sh	e cause of death?
ds	uires tha signed I	d by		•			ion, ing occoor gives						ably 4 Dunknown
cords	> 0 %	ete								10163	225(10)	3 1 1 1002	
d)	e ta has	ompleted								24a. Was an autopsy	pi	rior to con	sy findings available opletion of cause of
		O								performe		eath?	2□ No
VIta	Physicien: this certific ral director,	o Be	25. Was case referred to medical examiner?	ospital:/.				-		heck only one)			
ō	Phys r this ral di	Η,	1 Yes 2 No	28a. Date of Inju		28b. Time of	3 DOA 28c. Injury	` 4 ☐ Nur		5 Residence			)
0	ding F th. Tunera	tior	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	ay Year)	Injury	Work?	at } es 2 □ N		Describe how	injury occurre	a	
NISION	Atten r dea ctor y the	ertification;	3 ☐ Suicide 6 ☐ Could not be	28e. Place of In	iury - At hor	me, farm, stree		03 2 11		Location (Street	at and Alumbo	r or Dural	Route Number.
5	after after Dire	erti	4 Homicide	building, e	tc. (Specify)	)	n, raciory, office		201.	City or Town, S	State)	r or Hurai	Houte Number,
	spitu nours nerel / fillet	O	29a. Certifier 1 Certifying Phys	icien: To the best	of my know	viedge, death	occurred at the time	date and	place and	due to the as:	20(0) 001		No. d
	To the Hospital or Attending within 24 hours after death.  To the Funerel Director: Attencompletely filled in by the funerel Director.	edicai	(Check only 2 Medicel Exeminate)	er: On the basis of and manner st	or oxallillati	on and/or inve	stigation, in my opi	nion, death	occurred a	t the time, date	and place, a	nd due to	the cause(s)
	To the within To the Comp	¥	29b. Signature and title of certifier				29c. License			29d.	Date signed	(Month, D	Pay, Year)
	1		> Wham	m			D	326	09		/3		
	A JK	-	30. Name and address of person who cor	npleted cause of	death (Item .	23a) (Type, Pr	int)				- 1	03	
	/,		Kammelin Mi	than.	Tho	1106 6	Evaluti	in S.	+ · Ho	weDe	Grace	M	21078
	Stat		31. Date filed (Month, Day, Year)  MAY - 3 2005	. Registe	rar's Signatu	ire Land	4.						_
	Registra	Tr I	MAY - 3 2005	The die		ASS.							

		1 = For State Registrar	State of M	aryland / Dep <i>Ce</i>	artment of I			371. (70)	1. E.s.	
		Decedent's Name (First, Middle, La	nst)		runouto or	Death	2. Date of Dea	leg. No.	UU	3. Time of Death
Phys (Ma	ician dical	MARY GRADY DWYER	2				APRIL	Day 2.1	2005	7:05 A <sup>M</sup>
	niner	4a. Fecility Name (If not institution, gir	ve street and number)		4b. City, Town, o	or Location of Deat	th	4c. County	y of Death	
		SOMERFORD PLACE			ANNAPO				ARUNI	
Funera Directo		579-03-7335	Sex 7. Ag 1□ M 2 <b>∑</b> F	e (In yrs. last birthday 87 Yrs.	Months Days	If Under 24 Hrs Hours Min.		(, Year)	9. Birthp Coun SC	lace (State or Foreign try)
aryland •how		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation				1:	0d. Inside City Limits
Mary Fileh	to	FL BREVARD		MELBOURN	Œ					1 ☐ Yes 2 📉 No
th the	Director	10e. Street and Number		1	10f. Zip Code			10g. Citizen of	What Coun	try?
ath wi		1335 INDEPENDENC	E AVENUE		32940			USA		
21215-0036  d within 72 hours after death with the Maryland glene. ar than "natural", or Itams 23a or 28a-f ehow the Medical Examiner must be multiled at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 🕱 Widowed 4 □ Divorced	12. Was Decedent Armed Forces?  1  Yes 2  If Yes, Give Year or Dates:		Was Decedent of HI Yes, specify Cub 1 ☐ Yes 2 ☑ No	an, Mexican, Puer	Specify Yes or No- to Rican, etc.)		ce - Americ ck, White, of	
5-0 72 hd 72 hd	etec	15. Decedent's E (Specify only highest gr		(Give	dent's Usual Occup kind of work done	during most of wo	rking	16b. Kind of B	lusiness/Inc	lustry
within the same of	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	DO NOT use retire  MAKER	d)		OWN E	IOME	
N Pom		17. Father's Name (First, Middle, Last	1	ROFIE	PIANEN	18. Mother's Na	me (First, Middle,			
Maryland 2.  d 2 should be filed v th and Mental Hygie ?? Is marked other t traumatic event, th	To Be	J. HENRY GRADY				MARIE	DURANT			
200		19a. Informant's Name/Relationship ( JEAN BERRY/DAUGH	,,,,		ng Address (Street					
Heal Heal tam 2		20a. Method of Disposition	ITEK	20b. Place of Disp	QUEENS CO		Date Date	20c. Location	21666 City or To	
Battimore, permit. Pages 1 a Department of Hee Important: If item		1 Burial 2 X Cremation 3 C 1 Donation 5 Other (Special	fy)	CHESAPEAL	matory or other pla CE CREMAT LLC.	TON	3/2005	STEVEN		
Departiment Depart		21. Signature of Funeral Service Lice	HOLL on Sign	• F	2. Name and Addre ELLOWS, I 06 SHAMR(	HELFENBET	N & NEWN	AM FUNE	RAL H	IOME, P.A.
		23a. Pert1. Enter the disease, or comshock, or heart failure. List only	plications that caused	the death. Do not en					1019	Approximate Interval Between
Physicia	n	Immediate Cause (Final disease or condition	Co	wellac	Ami	Itoma				Onset and Death
/Medica Examine		resulting in death)	Due to (or as	a consequence of):	7	To copy of				
- Zamine	ē .	Sequentially list conditions,	b	a consequence oi):						
uted n		ri any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due 10 (01 &3	a consequence or,						
barbu, ficate be executed physician and s the burial-transit	Examin	that initiated events resulting in death) Last	c. Due to (or as	a consequence of):						
8/60 cate be e chysician the buris	dical		d							
Certifica certifica nding pt use as ti	Med	IF FEMALE:								
death death of for a	Physician/Me	23b. Was decedent pregnant in the past 12 months?  1  Yes 2  o	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)	<i>y</i>			te of deliver onth	ry Day Year
ords, F.C requires that the een signed by th hould be detache	by Ph	Part II. Other significant conditions	contributing to death b	ut not resulting in the u	nderlying cause giv	ren in Part I.	23e. Did to	pacco use cont	tribute to the	e cause of death?
COLOS w requires been sign should be		Dewelia					1 □ Y	as 2□No	3 🗌 Proba	ably 4 Unknown
S = 0 0	Completed	Karluse	to	thrue	_		24a. Was a	n 24b.	Were autop	sy findings available
The The ate h	Som						autops perfor	ned?	prior to com death? 1 🗌 Yes :	
OI VILAI F Physician: Th this certificate ral director, pag	Be (	25. Was case referred to medical examiner?				26. Place of Dea	ath (Check only on	~		A
Phys this	2	1 □ Yes 2 No	Hospital: 1 Inpatie			4   Nursing F	lome 5 Reside		er (Specify,	HSSUEC
and the second	Certification:	27. Mann feath  1 Natural 5 Pending	28a. Date of Inju (Month, Da	ry Year) 28b. Time o Injury	Wor	yat k? Yes 2 ⊡No	28d. Describe ho	ow injury occur	red	aving
Atten deat ctor:	fica	2 Accident investigatio 3 Suicide 6 Could not b	e Ogo Place of Init	ury - At home, farm, st		163 2 110	28f. Location (Si	reet and Numb	er or Rural	Route Number
<b>5</b> 5 # 5 ⊆	Serti	4 Homicide determined	building, et	c. (Specify)	,,,		City or Town			,
e Fig.	edical (	29a. Certifier (Check only one) 1 Certifying Ph	nysicien: To the best miner: On the basis of and manner sta	of my knowledge, deat examination and/or in	h occurred at the tir vestigation, in my o	me, date and place pinion, death occu	, and due to the carried at the time, d	ause(s) and ma ate and place,	anner as sta and due to	ited. the cause(s)
To the Hos within 24 h To the Fun completely	₩ We	29b. Signature and title of certifier			29c. Licens	e number	2	9d. Date signe	d (Month, D	lay, Year)
(2)					7	57025	2	N.7	7.1	25
175		30. Name and address of person who	completed cause of d	eath (Item 23a) (Type,				7 /	de C	
/It		ADITYA CHOPI	RA,M.D.	600 Ric	igelyk	we. Ste.	231 Ann	rapoli	Sin	1D-21401
S Regis	itate strar	31. Date filed (Month, Day, Year) APR 2 2 20	32 Registra	ar's Signeture	- 00				-	
riegis	Artin	711 12 22 22	P. B. W.	U SU RE	34E)					

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			State of Maryland / Department of Health and Men		ne	
			1 - State Crivial yeard / Department of Health and Wern Registrer Certificate of Death		2000	10111
				Reg. No. 1	10, 00,	3. Time of Death
	Physicia		Tohu Duhe Jr.	Month E	26 2000	-2201 M
	/Medic Examin			- /-	4c. County of Death	
1	Examin	er	Howe Arundel Gen Hose Hunapolis	5	AA	
	Funeral	6		Date of Birth	9. Birthi	olace (State or Foreign
	Director		121-18-0361   13 M 2   F   79 Yrs.   Months   Days   Hours   Min.   Ja:	Date of Birth Month, Day, Yea n. 23,	1926 New	York
	D .		Usual Residence of Decedent			
	show	_	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits 1 ☐ Yes 2X No
	8a-f	ecto	Maryland Anne Arundel Davidsonville			
	within 72 hours after death with the Maryland one one. Itan "natural" or Items 28e or 28e-f show the Meuleal Examitter (wat be notified at	Funeral Director	10e. Street and Number 10f, Zip Code	10g. (	Citizen of What Cou	ntry?
	s 23	eral	2582 Tarmans Branch Crossing 21035  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify)	Ves es No	USA	oon Indian
	ter de Item	un.	11. Marital Status  12. Was Decedent Ever in U.S. Amed Forces?  1 □ Never Married 2 ☑ Married  1 □ Never Married 2 ☑ Married  1 □ Never Married 2 ☑ Married	n, etc.)	14. Race - Americ Black, White,	
99	ar, or	by §	If Yes, Give 1 Yes 2 No Specify: Year or Dates: WWII		Specify: Wh	ite
21215-0036	2 hou	ted	15. Decedent's Education 16a. Decedent's Usual Occupation	16b.	Kind of Business/In	dustry
7	hin 7 9.	ple	(Specify only highest grade completed)  (Give kind of work done during most of working life. DO NOT use retired)  Elementary/Secondary (0-12)  College (1-4or 5+)		C.I.A.	
N	od wil	Completed	5+ Operations Officer		C.I.A.	
힏	d oth	Be	17. Father's Name (First, Middle, Last)  18. Mother's Name (First)	st, Middle, Maide	en Sumame)	
yla	should be filed vind Mental Hygie on Mental Hygie of marked other tumatic event, III	10	Louis John Dube, Sr. Loretta		Hoogkamp	
Maryland	2 sh and Is m	n i	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Rot			
	1 and Health em 27 ther tr		Rachael Ann Dube/ Wife 2582 Tarnans Branch Cros		Davidsonv: Location - City or To	
סר	Pages nent of P ant: If its		1 Burial 2 Cremation 3 Removal from State cometery, crematory or other place)	200.	Location - City of To	SWII, State
Baltimore,			'4 □ Donation 5 □ Other (Specify)  Metropolitan Crematory 2005  21. Signature of Funeral Service Ucensee 22. Name and Address of Facility		exandria,	Virginia
Ba	permit. Departr Imports any inj		21. Signature of Funeral Service Licensee  Francis J. Collins Fun 500 University Blvd, N	neral Ho	ome Inc.	MD 20001
			23a. Pand. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or res		sr spring,	Approximate
L.			shock, or heart faiture. List only one cause on each line.	,		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)  a. //Cute Caldiae //thyth m	MIA		
Н	Examiner		Anterior levotic Heart	DEG	PASNE.	
		Jer	Sequentially list conditions	1010		
	cuted nd ransil	Examiner	Cause (Disease or injury that initiated events  Cause (Disease or injury that initiated events			
Ö,	e exe ian a urial-t					
8760,	cate be executed physician and the burial-transit	licai				
Ø ×	death certifica attending ph d for use as t	Physician/Med	IF FEMALE:			
Вох	attend for us	ian	23b. Was decedent pregnant in the past 12 months?		23d. Date of delive Month	ery Day Year
P. O.	that the de ed by the a detached	ysic	1  Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other (specify)			
٦	res that the igned by be detact	/ Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco	o use contribute to the	ne cause of death?
ds.	uires n sign	d by	Cerebrounscular Accident	1 Yes	2□No 3□Prob	pably 4 Unknown
Records,	w requir been s should	Completed		24a. Was an	24b. Were auto	psy findings available
Re	he la e has age 2	duc		autopsy performed?	prior to co	mpletion of cause of
ā	ysician: The law is certificate has t director, page 2 s	O	25. Was case referred to medical 26. Place of Death (Ch.	1 ☐ Yes 2 2	No 1 □ Yes	2 No
$\geq$	ysici is cer direc	To B	examiner?    Hospital: 1 Inpatient 2 KER/Outpatient 3 004 Other: 4 Nursing Home		6 Other (Specific	y)
Division of Vital	r Attending Physier death. rector: After this c			Describe how in		
O	ttendig death. ctor: Al y the fu	atic	2 Accident investigation M 1 Yes 2 No			
Ξ	or Att	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	Location (Street a City or Town, Sta	and Number or Rura ate)	l Route Number,
	urs a urs a sral D					<u>`</u>
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edicai	29a. Certifier (Check only one) (Check one) (Check only one) (Check one) (Check only one) (Check only one) (Check only one) (Check one) (Chec	due to the cause( t the time, date a	(s) and manner as si ind place, and due to	tated. the cause(s)
	o the o the omple	Me	29h Signature and title of certifier 29c License number	29d. D	Date signed (Month,	Day, Year)
) .	< X \		1/1/1/1 Danno D0006054	-	4/28/	5
1	(>1,		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		. / . / .	
			William D. Tones, mo 1095 Atmo	ricA	210	35
	Sta		31. Date filed (Month, Day, Year)  33. Registrar's Signature			
	Registr	ar	MAY 0 2 2005 deliver to Agree			

			1 - For State Registrar	State of N	Maryland / Depa <i>Ce</i>	artment of H			giene 005	164	42
			1. Decedent's Name (First, Middle, La	ast)				2. Date of Dea		3. Time o	f Death
ı	Physici		Aristides		Ekono	omo		Month April 29	Day Yea 9, 2005	4:15	рм
	/Medic		4a. Facility Name (If not institution, gi	ve street and numbe	ir)	4b. City, Town, or	r Location of Death	<del></del>	4c. County of De	ath	
			Montgomery Gen	eral Hosp	ital		Olney		Montg	omerv	
	Funeral		5. Social Security Number 6.	Sex 7. A	Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. B	irthplace (State	or Foreign
	Director	ľ	573-60-5794	1 <b>X</b> M 2□ F	83 Yrs.	Months Days	Hours Min.	(Month, Day Sept. 7		Coun <i>try)</i> Salvad	or
	D.		Usual Residence of Decedent					1.0000			
	thow	_	10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside 0	
	e Ma Sa-f	cto	Maryland Mont	gomery	Whe	aton				1 L Yes	2 <b>X</b> No
	if th	Director	10e. Street and Number			10f. Zip Code		1	log. Citizen of What	Country?	
	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or items 23a or 28a-f show event, the Modical Examinational be indiffed at		12034 Milton Str			20	902			SA	
	r deg	Funeral	11. Marital Status	12. Was Deceder Armed Forces	nt Ever in U.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - An Black, Wi	nerican Indian, nite, etc.	
36	or it	by Fi	1 Never Married 2 Married	1 Tes 2 I		1⊠ Yes 2□ No	Specify: E1 S	Salvador	an Specify:	White	
21215-0036	ural'	d b	3 Widowed 4 Divorced	Year or Dates							
Ÿ	"nat	Completed	15. Decedent's E (Specify only highest gi	ade completed)	(Give	dent's Usual Occup kind of work done of DO NOT use retired	durina most of work	ring	16b. Kind of Busines	ss/Industry	
N	within iene.	m d	Elementary/Secondary (0-12)	College (1-4o	r 5+)		2)		Transpor	.+.+	
	filed Hygie other		17. Father's Name (First, Middle, Las	t)	UF:	iver	18 Mother's Nam	e (First Middle	Maiden Sumame)	cation	
an a	l be f	Be	Domingo Ekonomo	•/				Canizal			
Maryland	should be nd Mental marked o	<sup>2</sup>	19a. Informant's Name/Relationship	(Time Drint)	10h 14niii	Addr (Cam-A			r, City or Town, State	7: 0: 41	·
<u>a</u>	d 2 sl h and 7 ier traur	11	Emma Ekonomo/ Wi								0050
a) —	1 and Healt		20a. Method of Disposition		20b. Place of Dispo				ville, Mai		0853
altimore,	o o o		1 ☐ Burial 2 ☑ Cremation 3 [	☐Removal from Stat	cemetery, crei	matory or other plac	(a) Mav	_	20c. Location - City (	or rown, State	
<u>=</u>	tant:		`4 □Donation 5 □ Other (Spec	-	Metropolita		20		Alexandria		
Ba	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic evonce.		21. Signature of Funeral Service Lice	ensee	F	Name and Address	ss of Facility Collins	Funeral	Home Inc lver Sprin		
	40.2 60		J. Alin Stiles								
L			23a. P. of . Enter the disease, or conshock, or heart failure. List only	nplications that caus y one cause on each	ed the death. Do not ent line.	er the mode of dyin	ig, such as cardiac	or respiratory arr	est,	Approxima Interval Be Onset and	tween
10	Pnysician		Immediate Cause (Final disease or condition	a Acute	Renal Failu	ire				5_Day	
	/Medical Examiner		resulting in death)		as a consequence of):	30000					
	Cxammei		Sequentially list conditions,	b Coliti							
	p #	iner	if any, leading to immediate cause. Enter Underlying	Due to (or a	as a consequence of):						
	and trans	Examin	Cause (Disease or Injury that initiated events resulting in death) Last	c. Diabet							
Ď,	e exection stants		1630tting in Godin) Last	Due to (or a	as a consequence of):						
8760	icate be executed physician and s the burial-transit	dicai		_ d	<del></del>						
9	ing p	Mec	IF FEMALE:								
XOR	eath certific attending p	lan/Me	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	Ectopic pregnancy			23d. Date of d Month		Year
	he al	ပ	1 ☐ Yes 2 ☐ No	4□Pregnant 9□Unknown		Other (specify)			NOTE	Day	i eai
J.	The law requires that the death certific te has been signed by the attending is age 2 should be detached for use as	Physi	9 Unknown								
<u>က်</u>	igne bed	þ	Part II. Other significant conditions Hypertension, Hy			nderlying cause givi	en in Part I.		bacco use contribute		
Vital Records,	w require been sig should b	Completed	my per cension, my	pochyrote	1			1 4	es 2 □ No 3 □ I	Probably 4.A.	Unknown
ပိ	law r as be 2 sh	ple						24a. Was a		autopsy findings completion of o	available
I		,ou						perfori	med?   death?	s 2 No	
<u> </u>	nyaician: The law nis certificate has t director, page 2 s	Be	25. Was case referred to medical examiner?				26. Place of Deat				
	> 0 0	ToE	1 ☐ Yes 2 ☐ XNo	Hospital: 1 🕍 npa	tient 2 ER/Outpatier	nt 3 DOA Othe	er: 4 Nursing Ho	ome 5 Reside	ence 6 Other (Sp	ecity)	
10 [	= E		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of In (Month, D	njury 28b. Time o Day Year) Injury		y at		w injury occurred		
<u>S</u>	andir ath. or: Af	atlc	2 Accident investigation	on			Yes 2 □No				
DIVISION	i or Attend after death Director: ,	tifle	3 ☐ Suicide 6 ☐ Could not l 4 ☐ Homicide determined	28e. Place of I	njury - At home, farm, str etc. (Specify)	eet, factory, office		28f. Location (St City or Town	treet and Number or I	Rural Route Nun	nber,
$\bar{\Box}$	tai o rs aft al Di ed in	Certification:		04							
	tospi t hou uner	edical	29a. Certifier 1 Certifying P	hysician: To the bes	st of my knowledge, deat of examination and/or in	h occurred at the tin	ne, date and place,	and due to the c	ause(s) and manner:	as stated.	=)
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medi		and manner	stated.						,
	To Will	-	29b. Signature and title of certifier	010 11	2/1/	29c. Licenso		2	9d. Date signed (Moi	mi, Day, rear)	
			- XIVW	ender Q'	-cun, Mi)		57630		May 1, 20	05	
	2		30. Name and andress of person who					-			
	1,274		Anuradha Arun,  31. Date filed (Month, Day, Year)		301 Georgia		#209, S11	ver Spri	ng, MD 20	902	
	Sta Registr		WAY 0 2 20	05 General	strar's Signature	E)					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death, 1. Decedent's Name (First, Middle, Last) Day Year Month Physician 7:35 P<sup>M</sup> 29, April 2005 Bertha Nimmich Espersen /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Brighton Gardens Columbia Howard If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours 1 M 2 XF Yrs 1918 New York Director 101-12-6547 86 Oct 17, Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d, Inside City Limits 10b. County 10a. State 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 0 21144 USA Items 23a 7804 Cypress Landing Road Pages 1 and 2 should be filed within 72 hours after death 1 nent of Heatih and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Itema 23 Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4 Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Oscar Nimmich Anna Reed 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) P.O. Box 675 Rosepine, LA 70659 Anne Rhodes/daughter item 27 l 20b. Place of Disposition (Name of 20c. Location - City or Town, State May 2 20a. Method of Disposition cemetery, crematory or other place) Department of Important: If it any injury or o 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 2005 Arundel Crematory Odenton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Going Home Cremation Service 21. Signature of Funeral Service License Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 le Deve 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Alzheimer's Dementia years Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate the sequence of the Due to (or as a consequence of) Examine physicien and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. ian/Medical as IF FEMALE esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 4□Pregnant at time of death 5 Other (specify) Physic P.O. the 9 Unknown Š 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 No 3 Probably 4 Unknown ongestive heart Failure Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Anorexia 1 ☐ Yes 2 XNo 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Assisted Other: 4 Nursing Home 5 Residence 6 Nother (Specify Living) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 🔯 No 2 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) Certification: Hospital or Attending 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death, 2 Accident after death Director: 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 24 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier m D. D56531 May 2, 2005 ad cause of death (Item 23a) (Type, Print) 30. Name and address of person who con

State Registrar

MAY 0 3 2005

31. Date filed (Month, Day, Year)

32. Resistrar's Signature

Harry Li M.D. 10780 Hickory Ridge Road Columbia, MD 21044

			1 - For State Registra MEND#10 fperi	State of Maryland / Dep	partment of Health and Nertificate of Death		all a con
			Decedent's Name (First, Middle,	Last)	Timodic of Bodin	Reg. 2. Date of Death	3. Time of Death
	Physici		Barbara	Freeman		Month 4 2	Day 2005 3.25 a.M
	/Medic Examin		4a. Facility Name (If not institution,		4b. City, Town, or Location of Death	•	4c. County of Death
			HCR Manor Cure	2-Towson	TOWSON		Baltimore
	Funeral		5. Social Security Number	5. Sex 1 □ M 2 F 7. Age (In yrs. last birthda) 1 Yrs.	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	
	Director		Usual Residence of Decedent	<b>U</b> 5		2-21-1	1942 New York
	yland		10a. State 10b. County	10c. City, Town or	Location		10d. Inside City Limits
	ith the Marylan or 28e-f show	cto	Virginia Fairf	ax Alexan	dria		1 ☐ Yes 2 🛣 No
	vith th	Dire	10e. Street and Number	1 //100	10f. Zip Code 22306	10g.	Citizen of What Country?
	s 23e	erai	7208 Tavenner	Lane,#108 12. Was Decedent Ever in U.S. 13	. Was Decedent of Hispanic Origin? (Sp	acifu Vac or No-	USA  14. Race - American Indian,
21215-0036	within 72 hours after deeth with the Maryland ene. then "nature!", or items 23e or 28e-f show item Adical Examiner must be notified at	by Funeral Director	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 🛣 Divorced	Armed Forces?	If Yes, specify Cuban, Mexican, Puerto  1☐ Yes 2X No Specify:	Rican, etc.)	Black, White, etc.  Specify: Black
5-0	naturel',	Completed	15. Decedent's (Specify only highest	grade completed) (Giv	edent's Usual Occupation re kind of work done during most of work	ing 16b	. Kind of Business/Industry
121	within ane. <b>then</b>	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)	Chef	E	ood Service
	filled hygie		17. Father's Name (First, Middle, La	· · · · · · · · · · · · · · · · · · ·		e (First, Middle, Maid	
Maryland	2 should be filed withir and Mental Hygiene. Is marked other then eumetic event, the M	To Be	Michael Ricar	rdo		ence	Wallace
ary	2 shou and N is mai		19a. Informant's Name/Relationshi		iling Address (Street and Number or Run		
	1 and 2 Health em 27 i				Running Court E.		21221
Saltimore,	8 2 2 5		20a. Method of Disposition  1  Burial 2 Cremation 3  4  Donation 5 Other (Spe	Metropol	itanCrematory 04/2	7/2005 AI	. Location - City or Town, State <b>exandria</b> , <b>Virginia</b>
Balt	permit. Pag Department Importent: I any injury o		21. Signature of Funeral Service		22. Name and Address of Facility Old 205 Belle Haven R		uneral Choices dria, Virginia22307
г			23a. Part1. Enter the disease, or c shock, or heart failure. List or	omplications that caused the death. Do not e nly one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	DEMENTA			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence of):		An	
	w	e	Sequentially list conditions, if any, leading to immediate	b. VEPENED (E Due to (or as a consequence of):	ENERROUKCHLAR	Acc i De	25
	uted d ansit	Examiner	if any, leading to inmediate cause. Enter Underlying Cause (Disease or injury that initiated events				
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8760,	cate be ex physician the buria	dical		d,			
9	ertific ding p	a a	IF FEMALE:	23c. If yes, outcome of pregnancy			
Вох	eath certific attending p I for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 ☐ Fetal death 3	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery  Month Day Year
0	the d	hysi	1 ☐ Yes 2 🛣 No 9 ☐ Unknown	9□ Unknown			
S, P	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	by P	Part II. Other significant condition	s contributing to death but not resulting in the	underlying cause given in Part I.		co use contribute to the cause of death?
ord	w requir been si should	ted	CND S	MAGE KENALFA	ILUILE	1 Tes	2 No 3 Probably 4 XV nown
Records,	law r nas be e 2 sh	Completed	DIABE	TES MELLITIS	TYPEIL	24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
al F	ding Physicien: The law h. After this certificate has b funeral director, page 2 s					performed 1 ☐ Yes 2	7 death? No 1 ☐ Yes 2 ☐ No
Vital	Physicien: this certificatal director, I	Be	25. Was case referred to medical examiner?	Hospital:	Othor	(Check only one)	
of	Phy this ral d	To To	1 Yes 2 No 27. Manner of Death	28a. Date of Injury 28b. Time	of 28c. Injury at	me 5 Hesidence 28d. Describe how in	6 ☐Other (Specify)  njury occurred
ion	nding Fath. r: After e funer	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investiga		Work? M 1 ☐ Yes 2 ☐ No		
Division	r Attendi er death. rector: A by the fu	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		street, factory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number,
	itel o Irs aft rel Di						<u> </u>
	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the fune.	Medicai	29a. Certifier  (Check only 2 Medical Education)	Physician: To the best of my knowledge, de- xaminer: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, investigation, in my opinion, death occurr	and due to the cause ed at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier		29c. License number	29d.	Date signed (Month, Day, Year)
•	2		" walty to	Sun	123450		4/25/05
			30. Name and address of person y	ho completed cause of death (Item 23a) (Type		21082	
	Sta	ate.	31. Date filed (Month, Day, Year)	32 Registrar's Signature		0000	
	Registi		MAY 02	2005 32 Registrar's Signature	08402		

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

Amen	nded it	State of Mar em #8,5/3/05, per/f.home, E.T 1. Decedent's Name (First, Middle, Last)	yland / Departmer WCHD Certifica		Re-	g. No. UU5	3. Time of Death
	Physician /Medical	MILDRED LUCINDA HUDS	ON		APRIL	28, 2005	
E	Examiner	4a Fecility Neme (If not institution, give street end number)  ATLANTIC GENERAL HOSPITAL		4b. City, Town, or L  BERLIN	ocation of Death	4c. County of Dec	
	uneral rector	222-10-0732 1□ M 2 <b>X</b> F	10 yrs. lest birthdey) If Under Months Months	r 1 Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Dey, SEP 28, 2	9/28/129. Bit	rthplace (State or Foreign ountry) RYLAND
hylend	show id.et	Usual Residence of Decedent	0c. City, Town or Location SELBYVILLE				10d. Inside City Limits
the Ma	be notfled Director	10e. Street end Number		p Code	10	g. Citizen of What C	1 X Yes 2 □ No
with	3a or	RT - 2 BOX 232		975	10	UNITED S	
:1215-0036 within 72 hours efter death with the Marylend ene.	nd other than "natural", or items 23a or 28a-f show event, the Medical Enarrimer must be notified at Be Completed by Funeral Director	11. Maritel Status  1 □ Never Married 2 □ Married  3 ▼ Widowed 4 □ Divorced  12. Was Decedent Event Armed Forces?  1 □ Yes 2 ▼ No If Yes, Give Year or Dates:	er in U,S. 13. Was Dece If Yes, spe	dent of Hispanic Origin? (Specify Cuban, Mexican, Puerto	pecify Yes of No- Plican, etc.)	14. Race - Am Black, Whi	erican Indian, te, etc.
Maryiand 21215-0036 d 2 should be filed within 72 hours ef th end Mental Hygiene.	nt, the Medical E Completed	15. Decedent's Education (Specify only highest grade completed)  Elementery/Secondary (0-12) College (1-4or 5+)	16e. Decedent's Usu (Give kind of we life. DO NOT L	ork done during most of worl use retired)	king	6b. Kind of Business	,
d Z filed v Hygie	the the co	8 17. Father's Name (First, Middle, Last)	WEIGH M		e (First, Middle, M.		AL NURSERY
land be Mentai	marked other martic event, I To Be Co	JOSEPH TIMMONS		EVA		ARMON	
Taryla 2 should lend Men	auma	19a. Informant's Name/Relationship (Type, Print)		s (Street and Number or Ru	ral Route Number,	City or Town, State,	Zip Code)
C =	itam 27 other tr	MARGARET BENT (DAUGHTER) 20a. Method of Disposition	RT. 2 BOX 20b. Place of Disposition (Na	234 SELBYVI		19975 Oc. Location - City or	Town State
E 9 5	7. F. P.	1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	DAGSBORO REDM CEMETERY	other place)	5/03/05	,	, DELAWARE
<b>Balti</b> pemit. Depertir	any in	21: Signature of Funeral Service Licensee	WATSON	nd Address of Fecility  FUNERAL HOMI ORO, DELAWAR			
/Me	sician edical miner	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. ATHEROS	e death. Do not enter the mod  CLEROTIC CARD  te to (or as a consequence of)	OVASCULAR_DI		st,	Approximate Interval Between Onset and Death  YEARS
	ding physicien end ise es the buriel-trensit	if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury	e to (or as a consequence of):				
Beath cer	d for use es iclan/Me	Part II. Other significant conditions contributing to death but r	not resulting in the underlying	cause given in Part I	23h Did toh	acco use contribut	e to the cause of death?
ords, P.O. BOX requires thet the death cert	ned by the ettending a deteched for use or y Physiclan/M	DEEP VEIN THROMBOSIS	or resulting in the anasyying t				Probably 4∑Unknow
	sete hes been signed be page 2 should be dete Completed by Pt				24a. Was an perform		Were autopsy findings available prior to completion of cause of death?
E 9	certificate has I lirector, page 2 s o Be Compl			· · · · · · · · · · · · · · · · · · ·	1∃ Vos	2 <b>K</b> No	1 ☐ Yes 2 ☐ No
OT VICEI Physician: T	r this certifice ral director, p	25. Was case referred to medical examiner?  1 ☐ Yes 2 🕱 No  Hospital: 1 ☐ Inpatient	2 X ER/Outpatient 3 ☐ D	Othor	th (Check only one	) ce 6 □Other <i>(Sp</i> e	no iful
o f	हु <u>।</u> ⊢	27. Menner of Death  1 1 Natural 5 Pending (Month, Dey Y) 2 Accident investigation		28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how		eciry)
	0 ~ -	a Could not be	- At home, farm, street, factor Specify)	y, office	28f. Location (Stre City or Town,	eet and Number or R State)	turel Route Number,
DIN To the Hospital or / within 24 hours effer	pletely fill edical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of manner: On the basis of exemple end manner stete	aminetion end/or investigation				
To the within	To the	29b. Signature and title of certifier		c. License number	296	d. Date signed (Mon	th, Dey, Yeer)
!		W Hanleel		D28769		5/3/2005	
~		30. Name and address of person who completed cause of deat					
8:1	State	NICHOLAS BORODULIA, MD 1209 31. Date filed (Month, Day, Year) 32. Refistrar's	Signature		AND, DE	19944	
F	State Registrar	MAY 0 3 2005	& Specific				

DHMH 16 Rev 6/95

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Vear **Physician** 12:20 P M 24, Walter Hanchak April 2005 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 18205 Darnell Drive Olney Montgomery If Under 1 Year If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1⊠M 2□ F 041-05-6412 87 Director April 5, 1918 Connecticut Usual Residence of Decedent Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f shov treumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Montgomery Olney the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18205 Darnell Drive 20832 USA items 23e Completed by Funeral filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Yes 2 No WWII 1 Never Married 2 Married ò Specify: White Baltimore, Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give Year or Dates: 3 Widowed 4 Divorced Korea "neturei", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within 7 hand Mental Hyglene. 7 is marked other than ": Elementary/Secondary (0-12) College (1-4or 5+) Technical Representative Electronics 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Paul Leonty Honchar Anna Ignatius Huber 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 siment of Health an Mary B. Hanchak/ Wife 18205 Darnell Drive, Olney, Maryland 20832 other! 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition May 17, 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Bernoval from State ŏ Department of importent: If eny injury or once. 2005 Arlington National Cemetery Arlington, Virginia \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc 21. Signature of Funeral Service Licensee 500 University Blvd, W., Silver Spring, MD 20901 23a. Part F. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death nmediate Cause (Final Priysician Atherosclerotic Cardivascular Disease disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Hypertension S quentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed burial-transit Hyperlipidemia Due to (or as a consequence of): Box 68760. physician Physician/Medical the IF FEMALE use s 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. 9 pe 1 Yes 2 No 3 Probably 4 XUnknown director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 2⊠ No 1 ☐ Yes or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home St Residence 6 Other (Specify) 2 1 XYes 2 ☐ No 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending investigation 1X Natural 1 ☐ Yes 2 ☐ No after death. 2 Accident the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide Hospitel 24 hours a 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 ho To the Func completely f and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10+1 ,005 1Xa 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 20755 2480 Llewelyn Avenue, Fort George Meade, Rinku Mukherjee, M.D. 31. Date filed (Month, Day, Year) 🚜 Registrar's Signature State MAY 02 2005 Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

			1 - For State Registrar	St	ate of	Maryland		artmen rtificat			and M	lental Hy	giene Reg. No	21	105	161	. 1.5
	Physici /Medic		1. Decedent's Name (First, Mid Eleanor, H	. ,								2. Date of Do Month	eath Da		Year 2005	3. Time of E	
	Examir		4a. Facility Name (If not institute University of			or) 1 Conte	_	Ĩ	Belti.				40		y of Death		
	Funeral Director		5. Social Security Number  218-38-0419  Usual Residence of Decedent	6. Sex 1 ☐ M :		Age (In yrs. las	Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Bi (Month, Da JUNE 1	ay, Year,	36_	Coun	ace (State or try) (LAND	Foreign
	ne Maryland 8a-f show ciffied at	Director	10a. State 10b. Coun	ty LEGANY			Town or La	AND								nside City	
	ath with the 23a or 2		10e. Street and Number 114½ GREENE						1502				Ü	tizen of	What Coun	try?	
9000	be filed within 72 hours after death with the Maryland nat Hygiene. Id other than "natural", or itema 23e or 28e-f show event, the Medical Evertiest matter a refilled at	d by Funeral	11. Marital Status  1 □ Never Married 2 □ Mi 3 ☒ Widowed 4 □ Divorce	arried 1	as Decede med Force Yes 2x Yes, Give ear or Date	□No		Was Dece If Yes, spe 1 ☐ Yes		spanic Orion, Mexican Specity:	gin? (Spe , Puerto I	ecify Yes or No Rican, etc.)	D-		ce - America ck, White, e y: WH]	etc.	
21215-0036	e filed within 72 h al Hygiene i other than "natu vent, The Medica	Completed	15. Decedo (Specify only high Elementary/Secondary (0-12)				life.	kind of wo DO NOT u	rk done d se retired,	luring most		ng			usiness/Ind	ŕ	
yland	12 should be filed n and Mental Hygin is marked other raumatic event, I	To Be (	17. Father's Name (First, Middle MICHAEL FRANCE)	. ,	NDERG	SAST						(First, Middle			ne)		
Baltimore, Maryland			19a. Informant's Name/Relation KAREN LANCAS			ER	11'	711 L	ONG 2		E, C	I Route Numb	AND,	MD	2150	2	
timore	permit. Pages 1 and Department of Healt Important: If item 23 any injury or other 1		20a. Method of Disposition  1  Burial 2 Cremation  4  Donation 5 Other	(Specify)	al from Sta	ate cem	se of Dispo setery, cren ERLANI	natory or o	ther place MATO	RY 0	4/28	/2005			- City or Tov ERLANI		
Bal	permi Depar impo any ir		21. Signature Funetal Sen to	Mohen	Bi is that cau	Sed he death.	5	UPCH 202	URCH GREE	ME ST	RAL REET	HOME, CUMB	ERLA	ND,		1502 Approximate	
,	Pnysician /Medical		23a. Part 1. Enter the disease, shock, or heart failure. Li Immediate Cause (Final disease or condition resulting in death)	a	5. Due to (or	s a consequer	nce of):									Interval Betwee	en ath
8760,	cate be executed by sicien and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	<b>1</b> c	per	tiogan as a Disequer toniti as a consequer	5	lure		ausing	9 3	shock					
.O. Box 6	that the death certific ed by the attending p detached for use as	by Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ♥ No 9 □ Unknown	1 4	Live birth	me of pregnanc n 2 ∏ Fetal de t at time of deat n	eath 3	Ectopic pr							te of deliver	y Day Ye	ar
<u>α</u>	w requires that been signed by should be deta		Part II. Other significant condi	tions contribut	ng to deat	h but not resultii	ng in the ur	nderlying c	ause give	n in Part I.		23e. Did t	-	use cont		cause of dea	
Vital Records,	ysician: The law re is certificate has be director, page 2 sh	Completed									_	24a. Was autop perfo			prior to com death?	sy findings av pletion of cau	ailable se of
Division of Vit	A 유교	ertification: To Be	E [ ] / (00/00/1)	Hospita 28a ing tigation	a. Date of I		VOutpatien Bb. Time of Injury		8c. Injury Work	r: 4 □ Nur	sing Hom	(Check only one 5 Residuel Res	dence				
DIVIS	rs after de rai Directo	O	# [] Hottlicide	mined 286	building,	Injury - At home etc. (Specify)						8f. Location (S City or Tox	vn, State	)			ır,
	To the Hoapital or Attending I within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Medical	one)	ai	To the be n the basis nd manner	est of my knowle s of examination stated.	edge, death n and/or inv	estigation,	ın my op	inion, deati	i place, a h occurre	d at the time,	date and	place,	and due to t	he cause(s)	
)	10		29b. Signature and title of certif	h.	D. 0				. License						26 a		
v	D.B.		30. Name and address of perso	e D.C	).	22	Gree	11e		Ва	Itim	ore, M	D	21	201		
	Sta Registr	_	31. Date filed (Month, Day, Yea APR 2		32. Hogi	strar's Signature	1	conti	,								

Description Name   Color   Processing   Color   P				1 - For State Registrar		State of M	aryland		artment o <i>rtificate</i>			lental H	ygiene Reg. No			16449
FRIDA HICKLE  Parameter  Framework  Framewor		Dhyois	ion	1. Decedent's Nan	me (First, Middle, Las	1)							eath			3. Time of Death
Financial   Committee   A Sea   Se				FREDA	HICKLE											6:40 A M
Second Security Number   Second Private International Control of the Control of		Exami	ner	1			104/	Intu	4b. City, To	wn, or Location	on of Death		40			io
Use of Part   Description   The Company   Too. Co				5. Social Security	Number 6. Se							8. Date of B	irth Day, Year,	9. 1	Birthpla Cou <i>ntr</i>	ice (State or Foreign y)
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Physician Reduced Cause (Final Cause)	non	ages ant of nt: If If		1 🔀 Burial 2	□Cremation 3 □F		cem	etery, cren	natory or othe	r place)						
Physician Reduced Cause (Final Cause)	altir	artme ortan injur					DOMSE			-				MOEKLA	MD,	כוויז
Physician (Medical Examiner)  Physic	Ä	Per Imp		YEO	ng Pl.	lepche	rer		202 GRI	EENE S	TREET,	CUMBI	ERLAN	ID, MD	21	502
Paysicial   Redded   Redder	I			snock, or nea	artialiure. List only o	ne cause on each i	ne.			f dying, such	as cardiac o	respiratory	arrest,		Ir	iterval Between
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Second   S		cuted nd ransit	amr	that initiated event	S 🔳	C.										
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25. Was case referred to medical examiner?    1	Bo	atten I for u	clan	in the past 12	2 months?	1 Live birth	2 Fetal de	ath 3					- 1			ay Year
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25. Was case referred to medical examiner?    1		s that		~		ntributing to death b	ut not resultin	ng in the un	derlying caus	e given in Pa	rt I.	23e. Did	tobacco u	use contribute	to the	cause of death?
25. Was case referred to medical examiner?    1	ord	equire en sig ould b	ted t	DEF	1 ENTI	4						1 🗆	Yes 2	□No 3□	Probab	ly 4 <b>D</b> onknown
25. Was case referred to medical examiner?    1	ecc	law ra as be	ple											24b. Were	autopsy	y findings available
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Second	Vita	ician certific ector	00	examiner?		Inspital:				Out						
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29b. Signature and didress of person who completed cause of death (Item 23a) (Type, Print)  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  4/25/2005  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  29c. Date signed (Month, Day, Year)  29d. Date Signature and didress of person who completed cause of death (Item 23a) (Type, Print)  29c. License number  29d. Date Signature and didress of person who completed cause of death (Item 23a) (Type, Print)  29c. Date Signature and didress of person who completed cause of death (Item 23a) (Type, Print)	of	Phys this ral di			INO	1 Minpatie		1000		4 🗆					ecity)	
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29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29b. Signature and did east of person who completed cause of death (Item 23a) (Type, Print)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  30. Description of the cause (s) and manner as stated.  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier (Check only one)  29c. License number (Check only one)  29d. Date signed (Month, Day, Year)  4/25/2005  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  30a. Name and address of person who completed cause of death (Item 23a) (Type, Print)  30a. Name and address of person who completed cause of death (Item 23a) (Type, Print)	ā	s afte	Cert	4 🗀 Homicide		building, et	c. (Specity)					City or To	wn, State	)		
75 D Sabulal Das. M.D., 166 Kilford ST. # 5048 MD 21804		P Hospi 24 hour P Funer etely fills		(Check only	1☐ Certifying Phys 2☐ Medical Exami	ner: On the basis of	t examination	dge, death and/or inv	occurred at the	ne time, date my opinion, d	and place, a leath occurre	nd due to the d at the time,	cause(s) date and	and manner and di	as state	ed. e cause(s)
75 D Sabulal Das. M.D., 166 Kilford ST. # 5048 MD 21804		To th within To the	Me	29b. Signature and	d title of certifier								29d. Dat	te signed (Moi	nth, Daj	y, Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Babulal Das. M.D., 166 Kilford ST. # 504B MD 21804				1	an M.D				D	579	152		4	1/25	1/2	005
State Registrar  31. Date filed (Month, Day, Year) APR 2 8 2005  Registrar's Signature				30. Name and add	ress of person who co	empleted cause of d	leath (Item 23	la) (Type, F	Drint)					<del></del>		
	ı		_	31. Date filed (Mor	PR 2 8 200	Registr	ar's Signature	Soa	elle)						-	

amend item/8, per Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amended #20b per FH; FCHD Certificate of Death tm 5/3/05 Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** APRIL 2005 NORMAN JOHNSON 26 7:17 P M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner FREDRICK MEMORIAL HOSPITAL FREDERICK FREDERICK | Months | Days | Hours | Min. | 8. Date of Birth | 2/22/55 | 9. Birthplace (State or Foreign (Month, Day, Year) | FREDERICK (M.S.) 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** 10M 2 F Months 084-50-154 Yrs. 50 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits item 27 Is marked other then "naturel", or Items 23e or 28e-f show other traumatic event, the Medical Exeminar must be notified at 1 Yes 2 □ No REDERICH Completed by Funeral Director REDERIC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with ATHERIDGE DR. HA 21702 U. S 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 Is marked other then "natural", or itel 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: BLACK Specify: 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Laborer .4RS. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Edith MAE JOHNSON Informant's Name/Relationship (T. e, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 Is any injury or other trainonce. 750 HEATLERIDGE DR md. 21701 10hNSON Date U5 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Smithsbury MITHS BURY CREMATORE ¹ 4 □Donation 5 □Other (Specify) 22. Nam and Address of Facility GAREI L. ROLLINS FUNERALHONE 21. Signatore of Funeral Service Dicensee South 57. FREDERICK 23a. Part 1. Entarche disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** nemorrhag /Medical Due to (or as a consequence of): Examiner Multi-019 a Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Anoxic the attending physician and thed for use as the burial-tran Due to (or as a consequence of) f  $\mathcal{U}^{\mathcal{U}}(\mathcal{U} = \emptyset)$  Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4 Pregnant at time of death 5 Other (specify) naral Diractor: After this certificate has been signed by the a filled in by the funeral director, page 2 should be detached i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an rmed? 2 No Yes To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 No 1 🗌 Yes 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of Injury Certification; 28d. Describe how injury occurred Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funaral E Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0061487 selling ludu 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ST. FRED. Md. 400 W.

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day

strar's Signature

2005

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State of Maryland / Department of Health and Mental Hygiene per phy 05/04/05 Certificate of Death

Decedent's Name (First, Middle, Last)

State of Maryland / Department of Health and Mental Hygiene per phy 05/04/05 Certificate of Death Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 3. Time of Death Vaar **Physician** 1:30A M Lena Ellen Johnson May 2005 02 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Harford Memorial Hospital Havre de Grace Harford Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sax **Funeral** Days 1□M 2€ F Months Hours Director 73 09/02/1931 Virginia 227-36-2776 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28e-f show traumatic event, the Medical Examiner must be notified at 1X Yes 2 No Director MD Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 6 Items 23e 21001 U.S.A. Completed by Funeral 8 East Inca Street 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married White Maryland 21215-0036 ŏ 1 ☐ Yes 2 ☒ No Specify. Specify: 3 XWidowed 4 ☐ Divorced "netural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 12 should be filed within 72 h and Mental Hygiene. 7 Is marked other than "no Elementary/Secondary (0-12) College (1-4or 5+) 0 Homemaker **Home** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ပ Jennie Belle Owens William Cebert Cole 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Item 27 2 East Inca Street, Aberdeen, MD 21001 Wyatt Earp Johnson (Son) other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 permit. Pages Department of Important: if It any injury or o 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 05/05/2005 Bel Air, MD \* 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Memorial Gardens 21. Signature of Funeral Service Licensee Tarring-Cargo Funeral Home, P.A. ellman 333 S. Parke St., Aberdeen, MD 21001 3a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** [NEUMONIA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner use as the burial-transit Cauco (Disease of Lijus that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 🗷 No 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital Records, þ 1 XYes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Dificile ClostRIDIUM 00/1 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After o the Hospital or Attending 1 Natural 5 Pending investigation <del>05</del> 1 Tes 2 No 2 Accident after death 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined

Division of

State

within 24 hours after To the Funeral Dir

Medical

Registrar

SWEAT MAN

D21338

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

501

15 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

HAVRE de GRACE, MD. 21078

HIAN

4 Homicide

(Check only one)

29b. Signature and title of certifier

29a, Certifier

31. Date filed (Month, Day, Year, 32. Registres Signature 4 2005 ▶ MAY

**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** BEULAH M. KOTCH 2005 12:00 AM May /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Salisbury

If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day) Wicomico Wicomico Nursing Home 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) 5. Social Security Number **Funeral** Months 1 ☐ M 2 🛣 F Yrs. PENNŚYLVANIA 206-22-2476 83 08-26-1921 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location f Health and Mental Hygiene. Item 27 is marked other than "natural", or Itams 23a or 28a-f show other traumatic event, the Medical Examinat must be notified at 1 Yes 2 No Director WICOMICO SALISBURY 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6348 RIAWAKER DRIVE 21801 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: Specify: WHITE 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JOHN CLUTTER ROSEANN DUFF 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a GLENN CLUTTER - BROTHER 6348 RIAWAKER DRIVE, SALISBURY, MARYLAND 21801 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ♥ Burial 2 Cremation 3 Removal from State 5 permit. Page Department of Importent: If any injury or once. HOLY NAME CEMETERY 05-04-2005 \* 4 ☐ Donation 5 ☐ Other (Specify) MONESSEN, PENNSYLVANIA 22. Name and Address of Facility BOUNDS FUNERAL HOME, INC. 21. Signature of Experal Service Licensee 705 EAST MAIN STREET, SALISBURY, MARYLAND 21804 23a. Park. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) CHRONIC OBSTRUCTIVE PULMONARY DISEASE **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Completed by Physician/Medical IF FEMALE nse 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? ō Day Year 4 Pregnant at time of death 5 Other (specify) detached P.0. 9 Unknown 9 Unknown signed 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. 8 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate USTFORDROSIS 1 Yes 2 No 1 Yes Division of Vital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funerel Director: After this completely filled in by the funeral director. 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 1 PCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0060515 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mahesha Thimmarayappa M.D. 614 Easternshore Dr Salisbury MD 21804 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State MAY 0 3 2005 Registrar

DHMH 17 Rev 1/2001

			For State Registrar	State of M	•	epartment of F Certificate of			ene g. No,	
	Physicia		Decedent's Name (First, Middle, La.		Stanley	KLAVAN	-	2. Date of Death Month April 29	Day Year	3. Time of Death 3
	/Medio Examin		4a. Facility Name (If not institution, giv Washington Adven				r Location of Death a Park		4c. County of Deat Montgom	ery
	Funeral Director		5. Social Security Number 6. S 578-52-7416	6ex 7. Aς ▼ M 2□F	ge (In yrs. last birtho	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Jan . 3,	Year) 9. Birt Co 1939 Was	hplace (State or Foreign untry) hington, DC
	aryland show	-	Usual Residence of Decedent  10a. State  10b. County		10c. City, Town o					10d. Inside City Limits  1X□ Yes 2 □ No
	with the M a or 28a-f be notifie	Directo	DC  10e. Street and Number  7434-8th Street,	NW	Wasiiii	10f. Zip Code	20012	10	g. Citizen of What Co United Sta	untry?
)36	be filed within 72 hours after death with the Maryland tal Hyglene. d other than "naturel", or items 23a or 28a-f show event, the Madical Examinational be multired at	by Funeral Director	11. Marital Status  11 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces' 1 Yes 2 If Yes, Give Year or Dates:	Ever in U.S.	13. Was Decedent of H If Yes, specify Cub	dispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, White Specify: W	
9500-61212	filed within 72 hor Hygiene. Sther than "natura ant, Ire Madical	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12) 12	ducation ade completed) College (1-4or	5+) (C	ecedent's Usual Occup Give kind of work done fe. DO NOT use retire tatisticia:	during most of word)	tking ]	6b. Kind of Business/ Labor Depa Federal Go	rtment
and		To Be (	17. Father's Name (First, Middle, Last Benjamin K1					ne (First, Middle, M Ginsburg		
Maryland	d 2 shou th and M 7 Is mar treumat		19a. Informant's Name/Relationship ( Richard Klavan, B	Type, Print)		tailing Address (Street 4 - 8th St				
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any injuryen other treumatic evone.	1000	20a. Method of Disposition  1 \( \sum_{\text{Burial}} 2 \sum_{\text{Cremation}} 3 \sum_{\text{V}} \)  4 \( \sum_{\text{Donation}} 5 \sum_{\text{Other}} (Special)	Removal from State	20b. Place of D	isposition (Name of crematory or other pla	се) 05/0	03/05 2	Oc. Location - City or	Town, State
Baltıı	permit. F Departme Importar any injut		21. Signature J.F. heral Service Lice	• •		22. Name and Addre	ss of Facility Hebrew I	Funeral H	ome	20012
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98760,	icate be executed physician and physician and stree burial-transit	dical Examiner	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated avents resulting in death) Last	с	s a consequence of)	:				
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<u> </u>	uires that the de signed by the a Id be detached f	by	Part II. Other significant conditions	contributing to death	but not resulting in the	e underlying cause gr	ven in Part I.		acco use contribute to s 2 □ No 3 □ Pr	× .
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Division of Vital Records,	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	To Be	25. Was case referre * Lower   Section   1	Hospital: 1 Impat 28a. Date of Inj (Month, D	ury 28b. Tin	ne of 28c. Inju	ner: 4 - Nursing H	ath (Check only one dome 5 Resider 28d. Describe hor	nce 6 Other (Spe	cify)
Divisio	l or Attending after death. Director: After I in by the fune	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined.	28e. Place of Ir	njury - At home, farm tc. (Specily)	n, street, factory, office	1163 2 110	28f. Location (Str. City or Town,	reet and Number or Ru , State)	ural Route Number,
_	To the Hospital within 24 hours a To the Funeral Completely filled	Medical Co			of examination and/	death occurred at the ti or investigation, in my				
ı	,	Me	29b. Signature and title of certifier	1	//	29c. Licen	Se number	7	od. Date signed (Mon)	n, Day, Year
	Q		30. Name and address of person who Nasreen Kango,	completed cause of	death (Item 23a) (T	ype, Print) Ave., #205	, Takoma	Park, MD	20912	· · · · · · · · · · · · · · · · · · ·
	Sta Regist		31. Date filed (Month, Day, Year)  MAY 0 2 20		trar's Signature					

			1 - For State RegistrativeND#8perFH5/2/	State of Maryland	l / Depa <i>Cer</i>	rtment of H tificate of I	lealth and N Death		jiene 19g. No.	2005	15454
			Decedent's Name (First, Middle, Last)	OJ, HWIN, WOO				2. Date of Dea	th		3. Time of Death
	Physicia		Wells Bradford Ko	vm a nn				Month April	29 <b>.</b>	Year 2005	6:57 A <sup>M</sup>
	/Medic Examin		4a. Facility Name (If not institution, give s			4b. City, Town, or	Location of Death	April		County of Death	0;3/ A
	LAGITIII	C'	11206 Farmland Dr			North Be	thesda		Mo	ntgomer	·v
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la.	st birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day			place (State or Foreign
	Director		558 <b>-</b> 74-3115	M 2□F 51	Yrs.	Months Days	Hours Min.	10/26/2	.005	Germ	**
	p g		Usual Residence of Decedent								
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	Ba-f	cto	MD Montgomen	cy Nort	h Betl						Λ
	or 2	Director	10e. Street and Number			10f. Zip Code			10g. Citize	en of What Cou	ntry?
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	er de Items	Funerai	11. Maritar States	12. Was Decedent Ever in U.S Armed Forces?	. 13. V	Yes, specify Cuba	ispanic Origin? (Sp n, Mexican, Puerto	Rican, etc.)	'	Black, White	
36	rs aft	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 XYes 2 No 197 If Yes, Give Year or Dates: 200	_   1	☐ Yes 2🌠 No	Specify:		3	Specify: Wh:	ite
21215-0036	be filed within 72 hours after deeth with the Maryland tall Hyglene. Id other than "neturel", or Items 23a or 28a-f show of other than "neturel", or Items 23a or 28a-f show event, the Madical Examiner must be notified at	edi	15. Decedent's Educ		16a, Deced	ent's Usual Occup	ation	1	16b. Kind	d of Business/Ir	dustry
15	in 72 n "n	Completed	(Specify only highest grade		(Give :	kind of work done o OO NOT use retired	during most of work	ring			,
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au	lid be lenta rked ic ev	To B	John G. Kormann				Elsa We	11s			
Maryland	2 should be f and Mental f is marked of raumatic eve	-	19a. Informant's Name/Relationship (Type	эө, Print)	19b. Mailin	g Address (Street	and Number or Rui		r, City or	Town, State, Zi	Code)
Σ	alth alth 27 is		Matthew Kormann, Br	rother	2804 1	Rustic Ma	nor Cour	t, Glenw	700d,	Mary1a	nd 21738
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked eny injury of emer traumatic events.		20a. Method of Disposition	20b. Pla	nce of Dispos metery, cren	sition (Name of natory or other place	e) !	Date	20c. Loc	ation - City or T	own, State
Ĕ	Page nent ant: If		1 ☐ Burial 2 M Cremation 3 ☐ Re  '4 ☐ Donation 5 ☐ Other (Specify)	Ft.	Linco	ln Crema	tory 05/0	2/2005	Brent	twood,	Maryland
alti	permit. Departr Importe eny inju		21. Signature of Funeral Service License	* U A			ss of Facility S	-			
B	€ 3 E 5 B		Courtem Hosch	Many	10	040 Rocky	ille Pik	e, Rockv	/ille	, Maryl	and 20852
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the death.	Do not ente	er the mode of dyin	g, such as cardiac	or respiratory are	rest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Metastatic M							Onset and Death  1 Year
	/Medical		resulting in death)	Due to (or as a conseque							1 1001
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	p #	iner	any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	anea offi						
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o.	at the de by the a tached	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown	1(II )	Other (specify)					
0	that the ed by detac		Part II. Other significant conditions con	tributing to death but not resul	ting in the ur	iderlying cause giv	en in Part I.	23e. Did to	bacco us	e contribute to t	he cause of death?
ecords,	Se GD	d by	-					1 🗆 Y	es 2 🗆	No 3 □ Pro	bably 4 🖸 Unknown
Ö	w require been si should I	ompieted						24a. Was a		24b More sut	angy findings available
Rec	has has	mpi						autop:	sy	prior to co	opsy findings available empletion of cause of
a	ien: The l irtificate ha	O						1 ☐ Yes	2 X No		2 No
Vital	Physicien: this certific ral director.	Be	25. Was case referred to medical examiner?	lospital:		Oth	26. Place of Dear				
ot	Phys this ral di	: To	1 ☐ Yes 2 ☑ No 27. Manner of Death	1   Inpatient 2   E	R/Outpatien 28b. Time of	3 DOA	4   Nursing H	ome 5 X Resid 28d. Describe h			fy)
	ding l h. After funer	tion	1 Natural 5 ☐ Pending	(Month, Day Year)	Injury	28c. Injur Wor M 1.□	k?` Yes 2 □ No		,,		
isi	deat deat ctor: / the	lica	3 Suicide 6 Could not be	28e. Place of Injury - At hon	ne, farm, str			28f. Location (S	treet and	Number or Rur	al Route Number,
Division	after of Direct of Jin by	ertification:	4 ☐ Homicide determined	building, etc. (Specify)		, ,		City or Tow			
_	spite ours werel	O		sician: To the best of my know	rledge, death	occurred at the tir	ne, date and place,	and due to the c	ause(s) a	and manner as s	stated.
	ro the Hos Within 24 h To the Fur completely	edical		ner: On the basis of examination and resident stated.							
	vithin 2 To the complet	Me	29b. Signature and title of certifier	1//	•	29c. Licens	e number	2	29d. Date	signed (Month,	Day, Year)
1	x1)/			X_		D003	3293		Apri	1 29, 2	005
'	-12		30. Name and address of person who co	mpleted cause of death (Item	23а) (Туре,	Print)		5			
			Frederick Smith, I			Ave. Ste	1300, Ch	evy Chas	e, M	aryland	20815
	Sta	ite	31. Date filed (Marth Day, Year)	32 Aegistrar's Signatu	ire da	208: 2					

Please Type or Print in Black Indelible Ink	<b>Ensure All Copies</b>	Are Legible
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		For State Registrar	State of M	aryland	-	rtment of h				ene	7 14 1 0.0	
Physici		1. Decedent's Name (First, Middle	e, Last) LD KENNETH KI	ERENS				2. D Apr	ate of Death		3 Time of Death 10:10 A M	
/Medic Examin		4a. Facility Name (If not institution				4b. City, Town, o	or Location			4c. County of Death	1	
		Homewood at Cru				Frederi				Frederick		
Funeral Director		5. Social Security Number 234-54-1948	6. Sex 7. Ag	je (In yrs. la 70	ast birthday) O Yrs.	If Under 1 Year Months Days	If Under Hours	Min. (A	ate of Birth Month, Day, y 13,	9. Births 1934 West	olace (State or Foreign htry) Virginia	
aryland show	<u>.</u>	Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation				1	10d. Inside City Limits	
he Ma 28a-1 s	ecto	Maryland Frede	erick	Thu	urmont	101 7:- 0-1-	-		- 10	O'Nim - 1100 - 100	Yes 2 No	
with t		10e. Street and Number  1 Clarke Avenue	<u>.</u>			10f. Zip Code 217	88		10	g. Citizen of What Coul U.S.A.	ntry ?	
death ms 23	Funeral Director	11. Marital Status	12. Was Decedent	Ever in U.S	6. 13. y	Vas Decedent of F Yes, specify Cub		igin? (Specify	es or No-	14. Race - Americ		
pomit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If time 27 is marked other than "natural; or Items 23a or 28a-f show any injury or other traumatic svent, the Medical Examinar must be notified at once.	by	1 Never Married 2 Marr 3 Widowed 4 Divorced	If Yes Give	No	,	Yes, specify Cub			i, etc.)	Black, White, Specify: Whi		
72 ho	Completed	15. Deceden	nt's Education st grade completed)		16a. Deced	ent's Usual Occup	oation during mos	st of working	11	6b. Kind of Business/In		
vithin ne. han *	mple	Elementary/Secondary (0-12)	College (1-4or	5+)		kind of work done OO NOT use retire						
filed v Hygie ther t		12 17. Father's Name (First, Middle,	Last)			Security	1		st. Middle, Ma	Securit	У	
d be the the the the the the the the the th	To Be	Raymond Dorsey						a Fluba				
2 should be and Mental is marked c	-	19a. Informant's Name/Relations	ship (Type, Print)		19b. Mailin	g Address (Street				City or Town, State, Zip	Code)	
and 2 ealth a m 27 is	1	Michael E. Dubl	e (Son-in-la	aw)	1 C1	arke Ave	nue, '	Thurmon	t, Mar	yland 2178	8	
Pages 1 and of He		20a. Method of Disposition  1  Burial 2 Cremation	3 □Removal from State		ace of Dispos metery, cren	sition (Name of natory or other pla	сө)	Date	20	0c. Location - City or To	own, State	
Pag tment tant:		' 4 ☐ Donation 5 ☐ Other (S	Specify)	Smit		g Cremat	71 77			nithsburg,		
permit Depar Impor any in		21. Signature of Funeral/Service	Licensee	P	R(	OBERT E. 15 EAST	oss of Facili DAILI MAIN	EY & SO ST., TH	N FUNE URMONT	ERAL HOMES,	P.A.	
Physician /Medical		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	aa	ine;	04	er the mode of dyi	- 2	s cardiac or resp	oiratory arres	st,	Approximate Interval Between Onset and Death	
Examiner		Conventially list and ditions	Due to (or as	a consequ	ence ot):						/	
nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or Injury	Due to (or as	a consequ	ence of):							
rate be executed shysician and the burial-transit		that initiated events resulting in death) Last	CDue to (or as	a consequ	ence of):						-	
ficate physis the	edlo		d									
The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal	death 3	Ectopic pregnanc Other (specify) _	y 			23d. Date of delive Month	ery Day Year	
res that the de signed by the a		Part II. Other significant condition	ons contributing to death t	out not resu	lting in the ur	iderlying cause gr	ven in Part f	1. 2	3e. Did toba	acco use contribute to the	ne cause of death?	
w requires been sign should be	ted by	- Chrone	- 2 0 5 / CL	1691	17 PL	1/mon a	14 Dr.	jease	1 ☐ Yes	2 No 3 Prob	ably 4 Unknown	
	Completed								4a. Was an autopsy performe	prior to co death?	psy findings available mpletion of cause of 2 No	
Physician: This certificatel director,	Be C	25. Was case referred to medical examiner?				19	100000	e of Death (Che	eck only one,			
Physic this c	2	1 ☐ Yes 2 No	Hospital:	1	R/Outpatien	3 DUA				ce 6 □Other (Specif	γ)	
fte ne	tlon	27. Manner of Death  Natural 5 Pendin  2 Accident investig		y Year)	28b. Time of Injury	28c. Inju Wo M 1	rk?  Yes 2.∐		Jeschbe now	injury occurred		
To this Hospital or Attanding within 24 hours after death of the Funaral Director: After completely filled in by the fune.	Certification:	3 Suicide 6 Could determ	not be	jury - At hor tc. (Specily,	me, farm, stre	eet, factory, office			ocation (Stre lity or Town,	eet and Number or Rura State)	d Route Number,	
is Hospita 24 hours ne Funaral	edical C	29a. Certifier  (Check only one)  Check only one)  Medical	ng Physician: To the best Examiner: On the basis of and manner at	of examinati	vledge, death ion and/or inv	occurred at the ti estigation, in my o	me, date ar opinion, dea	nd place, and di ath occurred at	ue to the cau the time, dat	ise(s) and manner as s e and place, and due to	tated. the cause(s)	
To the withing To the comp	Me	29b. Signature and tiffe of certifie	or / /	/ <	-	29c. Licens	se number		290	d. Date signed (Month,	Day, Year)	
		Man	2411	nn	14	1 D16	5428			4/29/	105	
Ox		30. Name and address of person Casper E. Clin	e, III, MD	300	West 9	th Stree	et, Fr	ederic	k, MD	21701		
Sta Registr		31. Date filed (Month, Day, Year)	3 2005 32. F. Igisti	rar's Signat	ure A							

			For State	State of Maryland /	Department of Health and M Certificate of Death		000	
			Registrar  1. Decedent's Name (First, Middle, Last	3	Certificate of Death	Reg. N	10.2005	3 Time of Death
	Physicia	an	DEREK HIL	D		Month /	Day Year	2045PM
	/Medic				the City Towns of City	April 2		4073
	Examin	er	4a. Facility Name (If not institution, give	11	4b. City, Town, or Location of Death	4	tc. County of Death	Tax
			5. Social Security November 6. Se	DUNTY HOSPITA		9. Data of Righ	0.00	
	Funeral			7. Age (In yrs. last.	Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	Coun	lace (State or Foreign try) RSTOWN MD
	Director		Usual Residence of Decedent	50		MARCH 22	, 1933 / 1mgci	3700019 110
	land ow		10a. State 10b. County	10c. City, To	own or Location		1	0d. Inside City Limits
	Mary f sh	ō	md Mashin	19TON H	AGERSTOWN			1 ✓ Yes 2 ☐ No
	the 28a	ec	10e. Street and Number	J //	10f. Zip Code	10g. (	Citizen of What Coun	try?
	with Ba or	0	1804 CORVE	TT CT.	21740		USA	•
	within 72 hours after death with the Maryland ene. than "naturel; or items 23s or 28s-f show the Modical Exemptor most be notified at	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Americ	an Indian,
	fter o	듄	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No		Rican, etc.)	Black, White,	etc.
21215-0036	urs a	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify: BL	ACK
Ģ	2 ho	Completed	15. Decedent's Edu		6a. Decedent's Usual Occupation		Kind of Business/Inc	dustry
21	hin 7	pie	(Specify only highest grad	College (1-4or 5+)	(Give kind of work done during most of work life. DO NOT use retired)	nig .	01	. /
7	d wit	on		4 yrs	13/5hap		Ch	urch
g	be filed within 72 hours after death with the Marylan ital Hygiene. Id other than "naturel", or items 23a or 28a-f show event, the Mudical Extractive must be notified at	Be (	17. Father's Name (First, Middle, Last)	10-10	18. Mother's Name	e (First, Middle, Maid	en Surname)	
<u>a</u>	uld b Venta	2	NORWOOD M	ARTIN DOW	CRU LILLIA	an KE	t	
Maryland	ges 1 and 2 should be filed within to the Health and Mental Hygiene. If item 27 is marked other than or other treumatic event, it a Me		19a. Informant's Name/Relationship (T)	ype, Print) 1	9b. Mailing Address (Street and Number or Run	al Route Number, City	y or Town, State, Zip	Code)
	1 and 2 Health em 27 i		VALLERIE KEE		5332 ST. JAMES PLA		ERICK Med.	
<u>S</u>	ss 1 ar of Hea item		20a. Method of Disposition	-como	etery, crematory or other place)		Location - City or To	
Ĕ	Pages nent of int: If it iry or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ F  14 ☐ Donation 5 ☐ Other (Specify)		EHILL CEM. 4-3	0-05 14	AGERSTOW	NMO
Baltimore,	permit. Pages 1 Department of H Importent: If ite any injury or ott		21. Signature of Funeral Service Licens	600	22. Name and Address of Facility GA	R4 L. Rollin	US FUNERA	L HONE
m	Depariment of the parameter of the param		facul Kal	ell_	110 W. South ST			
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	lications that caused the death. D	Oo not enter the mode of dying, such as cardiac			Approximate Interval Between
	Enysician :		Immediate Cause (Final	no egoso on egon mio.	carried arrest			Onset and Death
	/Medical		disease or condition resulting in death)	a Due to (or as a consequence				
	Examiner				Soptic Shack			
	-	Je.	if any leading to immediate	b. Due to (or as a consequence				-
	cuted id ansit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events	c (	acute Pentonetis			
ó	exec an an rial-tr		resulting in death) Last	Due to (or as a consequence	ce of):			
8760	The law requires that the death certificate be executed ate has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	dicai		d.				
9	tifica ng ph as th	0 1	I F F F W F					
Вох	death certific attending pi	Physician/M	23b. was decedent pregnant	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea			23d. Date of delive	,
	deat	icis	in the past 12 months? 1 ☐ Yes 2 💢 No	4☐ Pregnant at time of death			Month	Day Year
P.0	that the de led by the a detached t	hys	9 Unknown	9LI OTIKTOWIT				
	res tha igned be det	by P	Part II. Other significant conditions co			23e. Did tobacc	o use contribute to th	,
p	w require been sig should b	ed	Human Immun	a reficiency hr	us	1 🗌 Yes	2 □ No 3 □ Prob	ably 4 Unknown
00	law requas been 2 shoul	piet	End Stage	- renel disease	e	24a. Was an	24b. Were autor	osy findings available
Vital Records,	The laste has page	Completed	Human Immiun End Stage hypert	onseon		autopsy performed? 1 Yes 2 2	death?	·
ta		Ф	25. Was case referred to medical			h (Check only one)	10 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	
>	Physicien: r this certific ral director,	0 8	examiner? 1 ☐ Yes 2∰No	Hospital: 1 ☐ Inpatient 2 ♣ P/	Outpatient 3 DOA Other: 4 Nursing Ho	me 5 Residence	6 ☐Other (Specify	1)
of	g Ph er th	Ë	27. Manner of Death	28a. Date of Injury (Month, Day Year) 28t	b. Time of 28c. Injury at Injury Work?	28d. Describe how in	jury occurred	
Division	nding ath. r: Aft	atio	1 □ Natural 5 □ Pending 2 □ Accident investigation	(World)	M 1 Yes 2 No			
Vis	Atte	ific	3 ☐ Suicide 6 ☐ Could not be determined	286. Place of injury - At nome,	, farm, street, factory, office	28f. Location (Street		l Route Number,
ā	el or s afte oi Dir	Certification;		building, etc. (Specify)		City or Town, Sta	····/	
	To the Hospitel or Attending P within 24 hours after death. To the Funerel Director: After completely filled in by the funer.		29a. Certifier 1 Certifying Phy	sician: To the best of my knowled	dge, death occurred at the time, date and place,	and due to the cause	(s) and manner as st	ated.
	n 24 n 24 he Ft	Medical			and/or investigation, in my opinion, death occur			
	To the vithic To the comp	Σ	29b. Signature and title of certifier	1 / +	29c. License number	29d. [	Date signed (Month,	Day, Year)
	,		bun la	ull Parti; Mi)	D 20233	1 4	121/05	
	6		30. Name and address of person who c	ompleted cause of death (Item 23	a) (Type, Print)	axt.	1/10/21/21	
	.)		BAPURAO PULIVAR	II, MD 12931	29c. License number D 20233 a) (Type, Print) O akhill Ave, Has	Crj 16m	MU 414	2
	Sta	ite	31. Date filed (Month, Day, Year)	2005 32. Resistrar's Signature	M Loans			
	Registr	ar	MATUS	LUUJ J				

			State of Maryland / Department of Health ar Certificate of Death	nd Mental F	lygiene Reg. No.	05 16457
			1. Decedent's Name (First, Middle, Last)	2. Date of Month		3. Time of Death
4	Physici /Medio		William S. Kirby	April	. 27 2	2005 3:23 PM
	Examir	ner		n, or Location of Do Annapolis		of Death : Arundel
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) If Under 1 Year If Under 24		Birth Day, Year)	Birthplace (State or Foreign Country)
	Director		192–18–4058 1X M 2□ F 80 Yrs. Months Days Hours	June June	29, 1924	Pennsylvania
	pue **		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Many Fired	tor	Maryland Anne Arundel Annapolis			1 ☐ Yes 2 [ No
	or 284	Oirec	10e. Street end Number 10f. Zip Code		10g. Citizen of V	Vhat Country?
	ath w	rall	8308 River Crescent Drive 21401	0.40		S.A.
020	within 72 hours efter death with the Maryland ene. than "naturel", or items 23s or 28s-1 show he Medical Examine: must be notified at	by Funeral Director	11. Meritel Status  1 □ Never Married 2 ◯ Married  1 □ Never Married 2 ◯ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U,S. Armed Forces?  12. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, I If Yes, Specify Cuban, Mexican, I I □ Yes 2 ◯ No Specify:	n? (Specify Yes or Puerto Rican, etc.)		e - American Indian, k, White, etc. :: White
20	72 hou	ted	15. Decedent's Education (Specify only highest grede completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of	of working	16b. Kind of Bu	siness/Industry
121	/ithin	mple	Elementary/Secondary (0-12) College (1-4or 5+) life. DO NOT use retired)	Working		
q 7	Hygie Hygie Ither the	ပိ	4 Supervisor   18. Mother's Neme (First, Middle, Last)   18. Mother's	s Name (First, Mide	Human dle, Maiden Suman	Resources
5	d 2 should be filed within the and Mentel Hygiene. 7 is marked other than traumatic event, the Mentel than traumatic event, the Mentel traumatic event	To Be Completed		la Gumper		,
lary	2 should be and N is mar is mar		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number of Street and Number of	or Rural Route Nu	mber, City or Town,	
	end Health m 27		Shirley Kirby/wife 8308 River Crescent  20a Method of Disposition (Name of			
Baltimore,	pemit. Peges 1 en Depertment of Heal Important: if item 2 any injury or other pnce.		Burial 2 Cremation 3 Removal from State	Date 5 / 2 / 2 0		City or Town, State SVille, MD
atir	permit. P Depertme importani any injuri pnce.		4 Donation 5 Other (Specify)  21. Signature of Funera) Service Licensee  22. Name and Address of Facility			
<u>~</u>	Dem Depe impo		Fodd & dille 147 Duke of Gloud			
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as ca shock, or heart failure. List only one cause on each line.	ardiac or respirator	errest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final			320-128
	Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Condition when the condition of the cond			134000
	ed sit	nine	Sequentially list conditions.  Due to (or as a consequence of):	ositi	S	years
<b>.</b>	ficete be executed physician end is the buriel-trensit	dicai Examiner	if eny, leeding to immediate	illatio		
68760,	ysicial	cai	Cause (Disease or injury that initiated events  Due to (or as a consequence of):		311	Jeans
	ertifice ling ph	<b>•</b>	Diabetes Mellitu	S		House
P.O. Box	ettenc for us	Physician/M				,
o.	the d	hysi	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		id tobacco use cor □ Yes 2D€io	attribute to the cause of death?  3 □ Probably 4 □ Unknown
S, T	es the igned be det	2				
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death certify thin 24 hours either death.  To the Funeral Director: After this certificete has been signed by the ettending completely filled in by the funeral director, page 2 should be deteched for use as	Completed		24a. W	as an autopsy informed?	24b. Were autopsy findings available prior to completion of cause of death?
丽	cete h	00			□ Yes 2X No	1 ☐ Yes 2 ☐ No
<u>=</u>	sician certifi irecto	o Be	examiner?	ing Home . 5 □ P.	<i>ly one)</i> esidence 6 ⊡Othe	or (Engelish)
סר	Attending Physician: or death. ector: After this certific by the funeral director,	n: To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at		e how injury occurr	
Sior	eath. or: Aff	catio	2 Accident investigation M 1 Yes 2 No			
	of or Att	ertifi	4 Homicide determined determined building, etc. (Specify)		n (Street and Numb Fown, State)	er or Rural Route Number,
	To the Hospital or Attending F within 24 hours efter death. To the Funeral Director: After completely filled in by the funer	edical Certification:	29a. Certifier (Check only one)  Check only one)			
	withi To t	×	29b. Signature and title of certifier  Ra KUSh OMONG Mi)  29c. License number  D20	108	29d. Date signed	(Month, Day, Year)
		-		0	T/2	1105,
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Dr. Rakesh Arora, MD 14300 Gallant Fox Lane Bowie	- MD 20	715	
	Sta		31. Dete filed (Month, Day, Year) 32. Recentrer's Signature	-, .w. 20	.12	
	Registr	ar	APR 2 9 2005			

			For State Registrar	1 1040	State of	Maryla	nd / Depa		of He	alth a		•	giene	05	16458
	Physici /Medic		1. Decedent's Name  Elmer Lero		Last)							2. Date of De	Day	Year CS	3. Time of Death
	Examir		4a. Facility Name (If I	HEAR	ET HOSP	ITAL	. last birthday)	-	Own, or Lo		GU	8. Date of Bir	A	LLEG A	h NY
	Funeral Director		215-14-6223 Usual Residence of E	3	1 <b>9</b> 0 M 2□F	83	Yrs.			Hours	Min.	8. Date of Bir (Month, Da 04-Jul-)		Mary	hplace (State or Foreign unity) vland
	e Marylan 3a-f ehow liffed at	ctor	Maryland	10b. County  Allega		Fros	ity, Town or Lo	ocation							10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	th with th 23a or 26 set be no	al Dire	10e. Street and Numl	<sup>er</sup> 16617 N	ational High	way, S.W	7.	10f. Zip (					10g. Citizen U.S.A.	of What Co	untry?
9800	be filed within 72 hours after death with the Maryland tal Hyglene.  Id other than "naturel", or items 23a or 28a-f ehow event, the Medical Evertiner must be notified at	Completed by Funeral Director	11. Marital Status 1  Never Married 3  Widowed 4	77	If Vac City	ces?		Was Decede If Yes, speci 1 ☐ Yes 2	_	anic Orig Mexican, Specify:	in? (Spec Puerto R	ify Yes or No ican, etc.)		Race - Ame Black, Whit ecify: White	
21215-0036	within 72 h ene. than "natu he Medical	mplete			Education grade completed) College (1-	4or 5+)	(Give	dent's Usual kind of work DO NOT use ire build	k done dur e retired)		of working		16b. Kind o	of Business	·
Maryland 2	should be filed within ind Mental Hyglene. s marked other than ' umatic event, the Me	To Be Co	17. Father's Name (F	irst, Middle, La	ist)		uuck t	ne omi					, Maiden Sur		Ing
	gges 1 and 2 should nt of Health and Men if Item 27 Is marke or other traumatic		19a. Informant's Nan Floyd Kroll		o (Type, Print) Son	20h	166171	Vational			or Rural rostb	urg		yland	21532
Baltimore,	Par Int		20a. Method of Dispo 1 Burial 2 4 Donation 5	Cremation 3 ☐ Other (Spe			Pla High we cometerly, create hart Ceme				26-Ap	τ-2005 I			Town, State
Ba	permit. Departn Imports eny inju		23a. Part I. Enter the	mR.	Rura	<del>/</del>	Du	rst Fune	eral Ho	ome, 5	7 Fro	· · · · · ·		irg, MI	21532 Approximate
	Priysician /Medical Examiner	niner	Amediate Cause (F disease or condition resulting in death)  Sequentially list concause. Enter Undert Cause (Disease or in	failure. List or inal	aDue to (o	ch line. or as a cons <i>e</i>	SE quence of): PM D	2129	7					1+	Interval Between Onset and Death 2 WEEKS
68760,	flicate be executed g physician and as the burial-transit	edicai Examiner	that initiated events resulting in death) La		c	or as a conse	quence of):								
P.O. Box	The law requires that the death certifica ste has been signed by the attending ph cage 2 should be delached for use as th	Physiclan/Med	IF FEMALE: 23b. Was decedent print the past 12 mm 1 Yes 2 yes 9 Unknown	onths?		th 2 ∏ Fet int at time of	aldeath 3□	□Ectopic pre □ Other (spe					23d.	Date of del Month	ivery Day Year
ecords, P	quires that in signed t uld be det	by	Part II. Other signific	ant condition NEW M		ath but not re	sulting in the u	nderlying ca	use given	in Part I.			obacco use d Yes 2 🗆 N		the cause of death?
$\mathbf{\alpha}$		Completed	D	MSTOL	IC CON	SUSTW	THA	VET F	AILU	(12F		24a. Was auto perfo 1 Yes		4b. Were au prior to death? 1 Yes	topsy findings available completion of cause of 2 No
Division of Vital	if or Attending Physiclen: The after death. Director; After this certificate he din by the funeral director, page	Certification: To Be	25. Was case referre examiner?  1 Yes 2 A  27. Manner of Death  1 Natural  2 Accident  3 Suicide  4 Homicide		28a. Date o (Month	Injury , <i>Day Year)</i>	ER/Outpatier  28b. Time o Injury	f 28	Other:  Ic. Injury a Work?  1  Yes	4 🗆 Nurs	sing Home	3d. Describe	dence 6 Inhow injury oc	curred	orfy) oral Route Number,
	To the Hospitel or Attend within 24 hours after death To the Funerel Director; completely filled in by the	edicai	(Check only 2 one)	Medical Ex	Physician: To the saminer: On the ba and mann	sis of examin	owledge, deat ation and/or in	vestigation, i	in my opin	ion, death	place, an	d due to the	date and pla	ce, and due	to the cause(s)
)	HIVA	N	29b. Signature and til	XV	r put	ysici.	M	29c.	D5		44		29d. Date sig	gned (Monti	n, Day, Year)
	12		30. Name and addre	_///_	JOSE C	of death (Ite	m 23a) (Type,	Print) 91	250	שטח	PRU	ECU	MBOX	ZCAND	1200S MD,21502
	Sta Registr		31. Date filed (Month)		2005	gistrar's Sign	ature	asser.							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 8 Time of Death Year Physician Elvira Legister April 25 2005 3:34 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick
Under 1 Year | If Under 24 Hrs. Frederick Frederick Memorial Hospital 5. Social Security Number If Under 1 Year 8. Date of Birth (Month, Day, Year) July 8,1937 9. Birthplace (State or Foreign Country) Panama 7. Age (In yrs, last birthday) **Funeral** Days Hours 1 M 200 Yrs Director 577-04-4203 67 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Items 23e or 28a-f show the Medical Exeminer must be notified at Silver Spring 1 ☐ Yes No Director MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20906 4103 Postgare Terrace U.S.A. Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married X Married Baltimore, Maryland 21215-0036 'naturel', or Black 1 ☐ Yes 2X No Specify: δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then any Injury or other treatment. Elementary/Secondary (0-12) 12th College (1-4or 5+) Nursing Ass't Adminis Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Cathwell Alfred Small 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20906 19a. Informant's Name/Relationship (Type, Print) 4103 Postgate Ter., Silver Spring, MD (Husband) Roberto Legister Injury or other to 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cem 5/4/05 Silver Spring, MD 4 □ Donation 5 □ Other (Specify) Signature Funeral Service Licersee 22. Name and Address of Facility Snowden Funeral Home, P.A. 246 N. Wash. St., Rockville, MD 20850 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. 23a. Part1. Enter the Approximate Interval Between Onset and Death Immediate Cause Final disease or condition resulting in death) Proysician HILLEVOSCIEVOTEC ardiovascular ears /Medical Due to (or as a consequence of) Examiner pertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due (or as a consequence of) certificate be executed burial-transit Due to (or as a consequence of): physician Box 68760 Physician/Medical as the b IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy į in the past 19 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Tyes 2 No 24a. Was an certificate has 2 No 1 Yes Hospitel or Attanding Physiclan: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes \_2 \[ No Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 X ER/Outpatient 3□ DOA this funeral 28c. Injury at Work? Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death. • Funeral Director: A 2 Accident investigation filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal (Check only one) To the I within 2 29b. Signature and title of certifier 3 ures 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD Man Sour

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

0 2 2005

2. Registrar's Signature

			1 - For State Registrar	S	tate of N	/larylar	nd / Dep <i>Ce</i>	artmen <i>rtificat</i>			and M	lental F	lygie Reg.	401	)5	16	460
п	Dhuaia	:	1. Decedent's Name (First, Midd	e, Last)								2. Date of Month		Day	Year	3. Time	of Death
	Physic /Medi		Claire	D			Lemans	ki				April				6:55	р м
	Exami		4a. Facility Name (If not institution			r)		4b. City,	Town, or	Location of	of Death			4c. County o	f Death		
			4407 Clearfie	eld Ro						er Spi					Mon	tgom	ery
	Funeral		5. Social Security Number	6. Sex 1 ☐ M			last birthday)	If Under Months	1 Year Days	If Under	24 Hrs. Min.	8. Date of (Month,	Birth <i>Day</i> , Ye	ar)	9. Birthp	lace (Stat	te or Foreign
	Director		154-18-2898			81	L Yrs.					Sept.	23,			Jer	
	and w		Usual Residence of Decedent  10a. State 10b. County			10c. Ci	ty, Town or Lo	ocation							1	Od. Inside	City Limits
	Mary f sho	٥	Maryland	Mont	gomery			Silver	Spr	ina							es X No
	ith the Marylan or 28e-f show	Funeral Director	10e. Street and Number					10f. Zip					100	Citizen of WI	hat Cour	ntn/2	
	with sa or	Ō	4407 Clearfie	a ba												, .	
	heath ms 2;	era	11. Marital Status			nt Ever in U	J.S. 13.		20906 dent of Hi		gin? (Spe	ecify Yes or	No-	US.		an Indian	
"	r Her	Fu	1 ☐ Never Married 2 ☐ Mai	ried 1	Was Deceder Armed Force: 1 ☐ Yes 2 <b>X</b>	s? ] No					, Puerto	ecify Yes or Rican, etc.)			, White,		'
030	al', o	by	3X☐ Widowed 4 ☐ Divorce		If Yes, Give Year or Dates	<b>:</b> :		1 Yes	2 <b>%</b> ] No	Specify:				Specify:	Whit	е	
21215-0036	72 hours after death with the Maryland natural, or items 23a or 28e-f show deal Examinan must be notified at	Completed by	15. Deceder (Specify only highe	it's Education	on maleted		16a. Dece	dent's Usua	al Occupa	ation	t of work	ina	16b	. Kind of Bus	iness/Ind	dustry	
7	thin 60.	pdu	Elementary/Secondary (0-12)		College (1-4o	r 5+)	life.	kind of wo DO NOT us	se retired	)	i oi worki	ng .					
7	ed wi	Son	12				Ho	memak	er					Own I			
pu	be fill tal H d oth	Be	17. Father's Name (First, Middle	•					İ	18. Mothe	r's Name	(First, Midd	lle, Maid	den Sumame	)		
yla	ould Men arke	P	Nicholas Moer									ine Ca					
Maryland	2 sh and Is m		19a. Informant's Name/Relation											ty or Town, S			
2	and lealth m 27 her to		David Lemanski	/ Son		201				ourt,			-	J, MD 2			
9	T to H		20a. Method of Disposition  1 Burial 2 Cremation	3 □Remo	oval from Stat		Place of Dispo cemetery, crea	natory or o	ne of ther plac	9)	May	3.	200	. Location - C	ity or To	wn, State	
Ë	men men tent:		'4 □Donation 5 □ Other (			Gate	e of Hea			,	200		-	ver Sp		g,Mar	yland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or items 23a or 28e-1 show amy principle other treumatic event, the Medical Examinar must be notified at once.		21. Signature of Funeral Service  23a. Part1. Enter the discussion shock, or heart faure. Lis	1.	Scer	lo	5	oo un	iver	sity	Blvc	, W,	Silv	lome Ir ver Spi	nc.	, Md	20901
8760,	Physician /Medical Examiner  the pniral-fransit the	cal Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a b c	Due to (or a	ls a consected the sale consected the sale consected the sale consected the sale consected the sale consected the sale consected the sale consected the sale consected the sale consected the sale consected the sale consec	rillat quence of): ellitu quence of):	ion	seas	е						Onset an	
O. Box 6	The law requires that the death certificate tie has been signed by the attending physoage 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		lf yes, outcom 1⊡Live birth 4⊡Pregnant 9⊡Unknown	2 Feta at time of c	Ideath 3[	Ectopic pr Other (sp						23d. Date Monti		ry Day	Year
Records, P.	uires that signed to Id be det	by	Part II. Other significant condition	ons contribu	uting to death	but not res	sulting in the u	nderlying c	ause give	en in Part I.		W .		co use contrib			f death? <b>∃</b> Unknown
000	sw require s been si	Completed										24a. W	as an	24b. We	ere autor	osy finding	s available
Re	The tav	mo										рө	lopsy rformed	? pri	or to con ath?	npletion of	cause of
Vital		0	25. Was case referred to medica							26 Place	of Death	1 Yes		NO IL	Yes	2□ No	
>	Physicien: this certific ral director.	To B	examiner? 1 ☐ Yes 2 ☐ No	Hosp	ital: 1 □ Inpa	tient 2	ER/Outpatier	nt 3 DO	A Othe					6 ☐Other	(Specific	()	
10			27. Manner of Death		8a. Date of In	jury	28b. Time o		8c. Injury Work		_			jury occurred			
ioi	Attending F r death. ector: After by the funer	atlo	1 Natural 5 Pendi		(Month, E	ay rear;	Injury	М		? ∕es 2 🗆 N	No						
Division	ol or Attence after death Director: d in by the	Certification:	3 Suicide 6 Could 4 Homicide determ		8e. Place of I building,	njury - At h etc. (Specii	ome, farm, str fy)	eet, factory	, office		2	28f. Location City or 7		and Number ate)	or Rura	Route Nu	ımber,
	To the Hospitel or within 24 hours after To the Funerel Director completely filled in the formal of the formal or the formal of the formal or	edical C	29a. Certifier 1 Certifyi (Check only one)	Examiner:	in: To the bes On the basis and manners	of examina	owledge, death	occurred vestigation,	at the tim	e, date and inion, deat	d place, a	and due to the	e cause e, date	(s) and manr and place, an	ner as sta d due to	ated. the cause	9(S)
	To the within 2 To the complet	Me	29b. Signature and title of certific					29c	License	number			29d.	Date signed (	Month, L	Day, Year)	)
			hair	my	i).	Po	MAIA	1	04733	30							
	13		30. Name and address of person			death (Ite-	n 23a) (Tuno		74/30	, 0			A	pril 2	9, 2	005	
			Thomas Joseph	, M.D.	50	W. E	dmonst	n Dri	ive,	Rock	ville	e, MD	208	52			
• • •	Sta Registi		31. Date filed (Month, Pay, Year, MAY 02	2005	States.	ual s sign	ature (1)	de									

			1 - For State Registrar	State of Mar		artment rtificate			nd Menta		ene 2005	6461
п	Physici	an	Decedent's Name (First, Middle, Last	)					2. Date Mor	of Death	Day Yeer	3. Time of Death
	/Media	ŝal	James Jerom		ry	T			Apr	il 29		11:13 <sup>a м</sup>
	Examin	ier	4a. Facility Name (If not institution, give 4808 Creek Shor					ocation of [	Death		4c. County of Dea	
	Euporol		5. Social Security Number 6. Se		(In yrs. last birthday	RO	CKVí Year	IIe If Under 24	Hrs. 8 Date	of Birth	Montgome	
	Funeral Director			<b>X</b> M 2□F	81 Yrs.	Months	Days	Hours	Min. (Moi	th, Day, Y	(ear) Co	thplace (State or Foreign buntry) nsylvania
	pu ,		Usual Residence of Decedent			<u> </u>						y=vanita
	aryla shov	-	10a. State 10b. County Maryland Me		10c. City, Town or L							10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	the M	Director	10e. Street and Number	ontgomery		Rock		e 				
	hours after death with the Maryland turel', or Items 23a or 28a-f show al Examinar must be notified at		4808 Creek Shore	∍ Drive		10f. Zip C	2085	2		100	g. Citizen of What Co US	•
	ms 23	Funeral	11. Marital Status	12. Was Decedent Ev	rer in U.S. 13.	Was Deceder	nt of His	panic Origin	? (Specify Yes	or No-	14. Race - Ame	
9	after or Item		1 ☐ Never Married 2X Married	Armed Forces?  1 ⊠ Yes 2 □ No If Yes, Give 19	242 45				? (Specify Yes Puerto Rican, e	tc.)	Black, Whit	
8	urel',	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	942-45	1 ☐ Yes 2	XI NO	Specify:			Specify: Whi	ite
21215-0036	72	Completed	15. Decedent's Edu (Specify only highest grad	ication le completed)	(Give	dent's Usual (	done du		f working	16	b. Kind of Business	Industry
12	within ene. than "	ш	Elementary/Secondary (0-12)	College (1-4or 5+) 4	)	DO NOT use	,					
<b>q</b> 2	il Hygi other		17. Father's Name (First, Middle, Last)	<b>T</b>	E;	stimato		8. Mother's	Name (First,		Constructi iden Surname)	lon
Maryland	id be ental kad o ic ave	To Be	Patrick Francis	Leary							es Condrar	1
ary	2 should be and Mental Is marked (sumatic av	-	19a. Informant's Name/Relationship (7)	rpe, Print)	19b. Maili	ng Address (S	Street an				City or Town, State, 2	
	s 1 and 2 should be filled if Health and Mental Hyg Item 27 Is markad othe other traumatic avent,		Mary Patricia Arl	in/ Daught							Maryland 2	
Ore	of He of He fitem		20a. Method of Disposition 1 □xBurial 2 □ Cremation 3 □ F	Compared from State	20b. Place of Dispo cemetery, cre	sition (Name	of	1	Date May 3,		c. Location - City or	
altimore,	Pag ment ent: I		`4 □Donation 5 □Other (Specify)		Cate of Hea	iven Cem	etery		2005	Si	lver Spri	ng,Maryland
Balt	permit. Pages : Department of H Importent: If ite eny injury or ot once.		21. Signature of Funeral Service Licens  J. Ken Skles		50	00 Univ	ers	ity B1	Lvd, W,	Silv		, MD 20901
	Physician		23a. Mart1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition	lications that caused the ne cause on each line.  Stomach		ter the mode of	of dying,	such as car	rdiac or respira	ito <b>ry arre</b> st	,	Approximate Interval Between Onset and Death 7 Months
	/Medical		resulting in death)	a	consequence of):							7 Horrens
п	Examiner		Sequentially list conditions	b								
	pe tis	Examiner	Sequentially list conditions, any loading to immediate cause. Enter Underlying Cause (Disease or injury	Dualic (or as a c	nonsaquanda uty							
	and and ul-tran	хап		c. Due to (or as a c	consequence of);							
8760,	icate be executed physician and s the burial-transit											
9	ifficate g phy as the	edic		1.								
Вох	death certificate be executed e attending physician and id for use as the burial-transit	Physician/Medical	230. Has decedent pregnant	3c. If yes, outcome of 1 ☐ Live birth 2 (		Ectopic preg	22201				23d. Date of deli	very
о. П	e dea he att	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at tin		Other (speci					Month	Day Year
<u>P</u>	res that the de signed by the a i be detached f	Phy	9 Unknown		ht							
ds,	signe d be c	d by	Part II. Other significant conditions co	tributing to death but i	not resulting in the u	nderlying caus	se given	п Рап I.	238		cco use contribute to 2 ☑ No 3 ☐ Pro	the cause of death?
COL	law requires as been sign 2 should be	Completed							- 1			
Vital Records,	0 L 0	ошо								. Was an autopsy performer	prior to c	topsy findings available ompletion of cause of
ta	ician: Th certificate rector, pag	e Co	25. Was case referred to medical					C Di	1 🗆		No 1 ☐ Yes	2 No
5	99 //-	0 B	examiner?	fospital:	2 ER/Outpatier	t 3[] DOA			Death (Check		e 6 Other (Spec	36.1
		n; T	27. Manner of Death	28a. Date of Injury (Month, Day Y	28b. Time o		Injury a Work?	1 1401511			injury occurred	ny)
0	Attending I r death. sctor: After by the funer	atio	1 ♣ Natural 5 ☐ Pending 2 ☐ Accident investigation	(World, Day )	(ear) Injury	М		s 2□No				
Division		ertification;	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (	- At home, farm, str (Specify)	eet, factory, o	ffice		28f. Loca City	tion (Stree or Town, S	et and Number or Ru State)	ral Route Number,
	pital c	0	X									
	To the Hospital or Al within 24 hours after or To the Funeral Direct completely filled in by	ledicai	one)	sicien: To the best of r ner: On the basis of ex and manner stated	tamination and/or in	vestigation, in	my opin	ion, death o	lace, and due to courred at the	time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To To con	Σ	29b. Signature and title of certifier	6		29c. L	icense n			29d.	Date signed (Month	,
	2441		Treet	40				045880	)		April 29	, 2005
			30. Name and address of person who co Leon C. Hwang, M	mpleted cause of deat	th (Item 23a) (Type, Piccard I	Print) Prive,	Rock	ville	, MD 20	850		
	Sta Registr	-	31. Date filed (Month, Day, Year) MAY 0 2 200	3 Registrar's	Signature Apple	uli						

			1 - For State Registrar	State of Maryla		artment of h			giene Reg. No.	1 1 1 1 1	164	62
	Physici	an	Decedent's Name (First, Middle, Last)     Doris Mae Lank					2. Date of Dea	ath Day	Year	3. Time of E	
	/Medi	cal	4a. Fecility Name (If not institution, give	strot and number		4b Cib. Town	-1	April 2			9:15	A <sup>M</sup>
	Examir	ner	11617 Lockwood Dri			Silver	r Location of Dea	m		County of Death [ontgome]	K17	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs	. last birthday)	If Under 1 Year	If Under 24 Hrs	8. Date of Birt	h Waarl	9. Birthp	lace (State or	Foreign
	Director		5/8-34-6363	]м 2 <b>)</b> ДГ 7.5	Yrs.	Months Days	Hours Min	8. Date of Birt (Month, Da 05/12/1	1929	Dist	rict of	Co1
	and		Usual Residence of Decedent  10a. State 10b. County	10c. C	ity, Town or Lo	cation				1	0d. Inside City	v Limits
	Many fied	ţō	MD Montgomen	is v	lver S	ring					1 🗌 Yes	
	th the	Director	10e. Street and Number			10f. Zip Code			10g. Citiz	en of What Cour	ntry?	
	23e c	ralD	11617 Lockwood Dri	ive #104		20904			U.S	.A.		
	er dez	Funeral		12. Was Decedent Ever in I Armed Forces?	J.S. 13. \	Vas Decedent of H	lispanic Origin? (s an, Mexican, Pue	Specify Yes or No- to Rican, etc.)		4. Race - Americ Black, White,		
36	rs aft	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give <sup>XX</sup> Year or Dates:		□Yes 2🌠 No	Specify:			Specify: Whi		
Maryland 21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. Id other then "neturel", or Items 23e or 28e-f show event, I're Madical Examire must be mailited at	ted	15. Decedent's Educ	cation	16a. Deced	lent's Usual Occup	ation		16b. Kin	d of Business/Inc	dustry	
215	thin 7	ple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give life. L	kind of work done OO NOT use retired	during most of wo d)	orking			<b>,</b>	
2	ould be filed withi Mental Hygiene. tarked other then tatic event, ITE M	Completed	unk		Homen	naker				Home		
and	0 = 0 >	Be	17. Father's Name (First, Middle, Last)					me (First, Middle,	Maiden S	Sumame)		
Ž	12 should be filed v and Mental Hygie I's marked other t reumatic event, II'	ပ	Louis Cook  19a. Informant's Name/Relationship (Ty)	pe. Print)	19h Mailin	n Address (Street	Nellie	unk ural Route Numbe	r City or	Town State 7in	Codol	
<i>®</i>	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked eny injury or other treumatic enge.		Paul Todd, Son					n Hill, 1				
ē,	of Height		20a. Method of Disposition	20b.		sition (Name of natory or other place		Date		ation - City or To		
altimore,	Pages ment of ent: If its ury or o		1 ☐ Burial 2 ∏ Cremation 3 ☐ R '4 ☐ Donation 5 ☐ Other (Specify)	amoval moin State				03/2005	Bren	twood, M	lary1an	.d
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	an = 0 a		Centyn Nasd	- [ Novy				e, Rockv		, Maryla		,52
	=		23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on Immediate Cause (Final						rest,		Approximate Interval Betwee Onset and De	
	Prrysician /Medical		disease or condition resulting in death)	Metastatic  Due to (or as a conse		11 ce11	Lung Car	cer				
	Examiner		Sequentially list conditions		44000 0.),							
	φ <del>=</del>	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter bridge or injury	Due to (or as a conse	quence of):							-
	be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a conse	Tuence of):							
3/60,	icate be executed physician and s the burial-transit	cal E		233 10 (01 43 2 3011381	1441100 017.							
80	certificate Iding phys	be										
XO RO	eath certific attending pl	ian/M	ZOD. Was decedent prognant	3c. If yes, outcome of pregn 1□Live birth 2□Fet		Ectopic pregnancy			23	3d. Date of delive	ry	
	ie death the atten hed for u	Physici	in the past 12 months? 1 □ Yes 2 X No 9 □ Unknown	4☐ Pregnant at time of o		Other (specify)				Month	Day Ye	ar
Ţ.	res that the de signed by the a be detached (	, Ph	Part II. Other significant conditions con	tributing to death but not re	sulting in the un	deriving cause give	en in Part I	23e. Did to	bacco use	e contribute to th	e cause of dea	ath?
S	requires een sign	d by		,	<b>3</b>	actifully according to				No 3 ☐ Proba		
ecord	₹ 0 v	ompleted						24a. Was a		24b. Were autop		
r	i <b>ician:</b> The la certificate has rector, page 2							autops perfor	SV I	prior to con death? 1 ☐ Yes	rpletion of cau	se of
νпаі	cian: ertifica	BeC	25. Was case referred to medical examiner?					ath (Check only or	18)			
_	hys his I di	P.	1 ☐ Yes 2 🙀 No	Water Control of the	ER/Outpatient	3□ DOA Othe	er: 4 ☐ Nursing F	lome 5 X Reside			)	
	ding Phys h. After this funeral di	tlon	27. Manner of Death  1   Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	rat ⟨? Yes 2 □ No	28d. Describe ho	ow injury (	occurred		
IVISION	Atten	ertification:	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At h	ome, farm, stre			28f. Location (St	reet and	Number or Rural	Route Numbe	er,
5	tel or s afte el Dire	Cert	4 - Homicide determined	building, etc. (Speci	fy)	*		City or Town	n, State)			
	To the Hospitel or Atlending P within 24 hours atter death.  To the Funerel Director: After t completely filled in by the funera	edical	29a. Certifier 1  (Check only one)  1  Certifying Phys 2  Medical Examin	ician: To the best of my knower: On the basis of examination and manner stated.	owledge, death ation and/or inv	occurred at the timestigation, in my op	ne, date and place pinion, death occu	, and due to the carred at the time, d	ause(s) ar ate and p	nd manner as sta lace, and due to	ated. the cause(s)	
	Veith Com	Σ	29b. Signalure and title of certifier			29c. License	number	2	9d. Date	signed (Month, D	ay, Year)	
			Paulfam	u			60335	- /	faril	28,	2005	•
			30. Name and address of person who cor	· ·		•	7 01	М- 1	1 0	•		
	Sta	te.	Paul Bannen, MD 181 31. Date filed (Month, Day, Year)	32 Registrar's Sign	111p Dr	. Ste.32	/, Olney	, Maryla	nd 20	J832		
	Registr		MAY 0 2 200	32 Registrar's Signa	7. April	ASSE						

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Records,
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n of
Division

		Please Type or Print in Bla  State of Maryland /	Depa	artment of Health	and Mental I		_	
		1 - State Registrar	Ce	rtificate of Death	<del></del>	Reg. I	vo.2005	16463
Physici /Medic		Decedent's Name (First, Middle, Last)  JAMES HENRY LAMB			2. Date of Month APRI		Pay Year , 2005	3. Time of Death  10:36P M
Examin	ier	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location	of Death		4c. County of Death	_
Euparol		CIVISTA MEDICAL CENTER  5. Social Security Number 6. Sex 7. Age (In yrs. last t	birthday)	LAPLATA  If Under 1 Year   If Under	24 Hrs. 8 Date of	Birth	CHARLE:	place (State or Foreign
Funeral Director		021-18-7420	Yrs.	Months Days Hours	Min. Sept.	14,	1923 Mas	sachuetts
nyland how		10a. State 10b. County 10c. City, To	wn or Lo	ecation				10d. Inside City Limits
e Ma	ctor	Maryland Charles Wal	ldor	f				1 ☐ Yes 2 X No
th with th 23e or 24	Funeral Directo	10e. Street and Number 952 Stone Avenue		10f. Zip Code 20602		10g. (	Citizen of What Cou USA	ntry?
ams ams	Iner	11. Marital Status 12. Was Decedent Ever in U.S. Amged Forces?	13.	Was Decedent of Hispanic Ori f Yes, specify Cuban, Mexicar	gin? (Specify Yes or	No-	14. Race - Ameri Black, White,	
ours afte	þ	1 ☐ Never Married 2 ☑ Married 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ No Specify:	, , , , , , , , , , , , , , , , , , , ,			hite
is 1 and 2 should be filed within 72 hours after death with the Maryland of the alth and Mental Hygiene. If the alth and Mental Hygiene. If the alth and Mental Hygiene, and Mental Mental the marked other than "natural", or Itams 23e or 28e-f show other traumatic avant, the Medical Examinet must be notified at	Completed	Dementary/Secondary (0-12) College (1-40r 5+)		dent's Usual Occupation kind of work done during mos DO NOT use retired)	t of working	16b.	Kind of Business/In	,
iled w tygier her th		12 17. Father's Name (First, Middle, Last)	<u>Ordr</u>	nance Worker			US Gover	rnment
d be find the  Be.	John Frederick Lamb			er's Name (First, Mid		,		
Shoulk Shoulk Ind Me mark Imatic	2		b. Mailin	ig Address (Street and Number	ith May G			Code
and 2: and 2: ealth ar m 27 is ner trau				Stone Avenue,		MD 20		(Code)
ss ta of Hei itam		20a. Method of Disposition 20b. Place	of Dispo	sition (Name of natory or other place)	Date		Location - City or To	own, State
Pages ment of h ant: If its ury or of		Dunai 2 Michamation 3   Nemoval from State			-3-05	Wa	aldorf, M	)
Dartilliolog, Mallylatid XIL permit. Pages 1 and 2 should be filed with Department of theatils and Mental Hygene. Important: If itam 27 is marked other than any injury or other traumatic avant, than once.		21. Signature of Euneral Service Licensee M01391	Hu P	Name and Address of Facility Intt Funeral H O. Box 156,	ome Waldorf I			
- 2-4		23a. Part: Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	not ent	er the mode of dying, such as	cardiac or respirator	arrest,	7004-015h	Approximate Interval Between
Frrysician		Immediate Cause (Final disease or condition Pneumoula						Onset and Death
/Medical Examiner		resulting in death)  Due to (or as a consequence	в <i>o</i> f):					
2.	-	Sequentially list conditions, if any, leading to immediate	n of):					
nsit	Examiner	Cause, Enter Underlying	9 01).					
e be executed /sician and e burial-transit	Exar	that initiated events c. resulting in death) Last Due to (or as a consequence	e of):				-	
cate be ohysicia the bur	cal	d.						
ntifica ng ph as th	Medi	IF FEMALE:		5 3179011				
leath certificate attending phys	Physiclan/Medl	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal deat		Ectopic pregnancy			23d. Date of delive	,
the a	ysic	1 Yes 2 No 4 Pregnant at time of death 9 Unknown	5 🗆	Other (specify)		-	Month	Day Year
that the de		Part II. Other significant conditions contributing to death but not resulting	in the un	iderlying cause given in Part I.	23e. Di	d tobacco	use contribute to the	e cause of death?
The law requires that the death certificate ten recover to the law requires that the death certificate ten as seen signed by the attending physoage 2 should be detached for use as the	ted by	COPD				]Yes 2		ably 4 ∐Unknown
	Completed				24a. W au pe 1 \( \text{Yes}	topsy rformed?	prior to cor death?	osy findings available inpletion of cause of
ysician: Th	Bec	25. Was case referred to medical examiner?		26. Place	of Death (Check onl		0 70 103	20110
hysic this call dire	2	1 ☐ Yes 2 ☑ No Hospital: 1 ☑ Impatient 2 ☐ ER/O	-		rsing Home 5 🗆 Re	sidence	6 □Other (Specify	')
ding Ph h. After th funeral	lon:	1 Natural 5 Pending (Month, Day Year)	Time of Injury	28c. Injury at Work?	28d. Describ	e how inj	ury occurred	
death ctor: y the	licat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, f	arm etre	M 1 Yes 2 N		(Stroot a	nd Number or Rura	I Cauta Alimba
spital or Attendinous after death.  aral Diractor: A	Certification:	4 Homicide determined 28e. Place of Injury - At home, f building, etc. (Specify)	aiii, stre	est, ractory, office	City or 1	own, Stai	re)	route Number,
To the Hospital or Attending Physician: within 24 hours after death.  To the Funaral Diractor: After this certific completely filled in by the funeral director.	edical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge of Medicel Examiner: On the basis of examination and manner stated.	je, death nd/or inv	occurred at the time, date and estigation, in my opinion, deat	d place, and due to the hoccurred at the time	e cause(: e, date ar	s) and manner as st nd place, and due to	ated. the cause(s)
To th withir To th comp	Me	29b. Signature and title of certifier		29c. License number		29d. Da	ate signed (Month, I	Day, Year)
		enstant.		0058095	5	4	1/300	
2001		30. Name and address of person who completed cause of death (Item 23a)		,		(	1	
DRASI		TONYA L. HARDY, MD 11345 PFM 31. Date filed (Month, Day, Year) 32. Registrar's Signature	BRO	OKE SQUARE	SUITE10	4 WA	LDORF,M	D 20603
Stat Registra		31. Date filed (Month, Day, Year)  MAY 0 3 2005  32. Restrar's Signature	1	berle				
	, i		7		·			

٠			1 - For AMEND#16b, 17 per FA tate of Maryland / Dep State Registrar ANNE ARINDEL CO HEALTH CMH 5/6/05 Co	partment of Health and I partificate of Death		iene <sub>eg. No.</sub> 2005	15454
	Physicia /Medic		1. Decedent's Name (First, Middle, Last)  George D. Lohrig		2. Date of Death	Day Year	3. Time of Death
	Examin		4a. Facility Name (If not institution, give street and number) 179 Topeq Drive	4b. City, Town, or Location of Death Sturna Park	n	4c. County of Death	. )
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda Yrs.	y) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Aug. 27		place (State or Foreign intry) MD
	thow thow		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or	Location Severna Park			10d. Inside City Limits
:	or 28e-f s	Director	MD Anne Arundel  10e. Street and Number	10f. Zip Code 21146	10	0g. Citizen of What Cou	1 □ Yes 2 X No intry?
	s 1 and 2 should be ling within 72 hours after death with the maryland if Health and Menhol Hygiene. It is marked other than "natural", or items 23e or 28e-f show other treumatic event, the Modical Examiner must be notified at	Funeral	179 Topeg Drive  11. Marital Status  1 □ Never Married 2 □ Married   12. Was Decedent Ever in U.S. Armed Forces?   1 □ Yes 2 ≥ No   1 □ Yes 2	3. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl	pecify Yes or No- o Rican, etc.)	USA  14. Race - Amer Black, White Specify: WI	
20 1	n /z nours "natural", cuical Exs	Completed by	15. Decedent's Education (Specify only highest grade completed)	cedent's Usual Occupation we kind of work done during most of work DO NOT use retired)	rking	16b. Kind of Business/I	ndustry Deli &
7 7 7	z snould be liled within and Mental Hygiene. Is marked other than eumatic event, Ite Ma		Elementary/Secondary (0-12)  12  College (1-4or 5+)  17. Father's Name (First, Middle, Last)	Meat Cutter	me (First, Middle, M	Butcher Sho	qo
ylair	d Mental I	To Be	George Lohrig, Sr.	Marie I		City or Town State 7	in Code)
			Susan Morrissey/Daughter 17	9 Topeg Drive, Sev	verna Par	•	16
_	rage ment c ent: If ury or		1 ☐ Burial 2 ②Cremation 3 ☐ Removal from State  '4 ☐ Donation 5 ☐ Other (Specify)  **Cemetery, completely, comple	ematory or other place) Ap	r. 30, 2005	Baltimore,	MD
0	Depart Import eny inj		for Carre	22 Name and Address of Facility Barranco & Sons, I 495 Ritchie Hwy, S	Severna P	ark, MD 21	146
F	hysician		23a. Part. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)	tive Pulmonary		951,	Approximate Interval Between Onset and Death
I	/Medical Examiner	ē	Due to (or as a consequence of):  Sequentially list conditions.	,			•
	loate be executed physicien and s the burial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):				
00/00	micate be g physicie as the bu	edical					
O. DOX	Ine law requires that the death certilicate be executed attents been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Me		B Ectopic pregnancy Other (specify)		23d. Date of deliv Month	rery Day Year
COIDS, T	quires that an signed by uld be deta	by	Part II. Dther significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		eacco use contribute to	the cause of death?
	sicient: The law requires that the death certificate has been signed by the attercetor, page 2 should be detached for	Completed			24a. Was ar autops perform 1 Yes 2	y prior to content?	opsy findings available ompletion of cause of
. Altal	rnysicien: rthis certific ral director,	To Be	25. Was case referred to medical examiner?  1 Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpati	ent 3 DOA Other: 4 Nursing H	ath (Check only one lome 5 Reside	e) nce 6 □Other (Spec	fy)
	ath. rr: After ti	atlon:	27. Manner of Death  1		28d. Describe ho	w injury occurred	
	tel or Atters of Directors of in by the	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Str City or Town	reet and Number or Rui , State)	al Route Number,
:	I o the fivespile of attending Physicien: Inel within 24 hours after death.  To the Funerel Director: After this certificate he completely filled in by the funeral director, page	edical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occu	irred at the time, da	ite and place, and due	to the cause(s)
1	with:	Z	29b. Signature artificity of certifier and mb	D coaa483		Od. Date signed (Month	Day, Year)  2005
			30. Name and address of person who be pleted cause of death (Item 23a) (Type STUART UACOBS mp 305 No	espital Dr. Glen	Burnie,	MD 210	61
₩.	Sta Registi		31. Date filed (Month, Day, Year)  APR 2 9 2005  32. Raistrar's Signature	front.			

			1 - For State Registrar	State of Mary	•	ertificate of			ene	16465				
1	Physici /Medic Examir	cal	1. Decedent's Name (First, Middle, Last REDHICK A 4a. Facility Name (If not institution, give	MC6	ELAN	4b. City, Town,	or Location of Death	2. Date of Death Month	Day 300 4c. County of De	3. Time of Death  3. Time of Death  1.10 M				
	Funeral Director		Usual Residence of Decedent	M 20F	yrs. last birthday	Months Days	If Under 24 Mrs. Hours Min.	8. Date of Birth (Month, Day, Y		Birthplace (State or Foreign Country)  MARYLAND				
	h the Marylar r 28a-f ehow r rollified at	Director	MARYLAND WICOMIC  10e. Street and Number		c. City, Town or L PITTS			100	g. Citizen of What	10d. Inside City Limits 1 ☐ Yes 2X No				
9036	within 72 hours after death with the Maryland ene. than "natural", or Itams 23a or 28a-1 ehow is Medical Evantinar must be notified at	by Funerai	6927 FRIENDSHIP  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	ROAD  12. Was Decedent Ever Armed Forces?  1 Z Yes 2 No If Yes, Give Year or Dates: 19	}	2185 Was Decedent of If Yes, specify Cub 1 ☐ Yes 2 No	Hispanic Origin? (Span, Mexican, Puerto	pecify Yes or No- Rican, etc.)	USA  14. Race - Ar Black, WI Specify:	merican Indian, hite, etc. WHITE				
Maryland 21215-0036	filed Hygi Sther ent, L	Be Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last)	cation e completed) College (1-4or 5+) 2	(Giv	edent's Usual Occuj e kind of work done DO NOT use retire AGENT	during most of work d)	king 16	INSURAN	ŕ				
Marylar	s should and Men le marka aumatic	ToE	NOAH  19a. Informant's Name/Relationship (Ty  S. ALLAN McGEE/SO	•				Eral Route Number, C						
Baltimore,	permit. Pages 1 and 2 Department of Health Important: If item 27 any injury or other tri once.		20a. Method of Disposition  1 \[ \sum_{\text{Burial}} 2 \subseteq Cremation 3 \subseteq F \]  4 \[ \sum_{\text{Donation}} 5 \subseteq \text{Other (Specify)} \]  21. Signature of Funeral Service Licensia	emoval from State	Ob. Place of Disp cemetery, cre DALE CI	osition ( <i>Name of</i> matory or other pla EMETERY 2. Name and Addre	4/28	Date 20 /05 WH	c. Location - City (	or Town, State				
Ī	Frrysician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused the le cause in each line.  Due to (or as a con	Myo D			ME, SELBY or respiratory arrest		Approximate Interval Between Onset and Death				
8760,	death certificate be executed e attending physician and for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Each of horizontal Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a con										
O. Box 6	the death certific the attending p ched for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	3c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	□Ectopic pregnancy	,		23d. Date of d Month	lelivery Day Year				
Records, P.	law requires that as been signed by 2 should be deta	by	Part II. Other significant conditions cor	tributing to death but no	t resulting in the u	inderlying cause giv	en in Part I.	23e. Did tobac		to the cause of death?  Probably 4 □Unknown				
Vital Rec	The ate h	e Completed	25. Was case referred to medical				26 Place of Death	24a. Was an autopsy performed 1 Yes 2	24b. Were a prior to death?	autopsy findings available o completion of cause of				
Division of Vi	ding Phye h. After this funeral di	Certification; To B	e 6  Other (Sp	recify)										
Divi	Dire		3 Suicide 4 Homicide  29a. Certifler (Check only  Medical Examir	28e. Place of Injury - building, etc. (Sp. ician: To the best of my	knowledge, deat	h occurred at the tir	ne date and place	City or Town, S	State)	Rural Route Number,				
)	To the Hospital  Within 24 hours a  To the Funeral I  completely filled	Medical	29b. Signature and title of certifier	er: On the basis of exar and manner stated.	M	29c. Licens		29d.	Date signed (Mor	nth, Day, Year)				
_	Sta	te	30. Name and address of person who co	MD (SA) 32. Registrar's S	TAL HOI	Print)	2. Bx 17	233 Sa	list 1	1-05 40 21802				
	Registra	S. 150	APR 2 9 201	15 Stern	J. A	nare								

ian												2. Date of MAYMING	, 20%	5 Year	3. Time of De 5:11 P		
cal ner	4a. Facilit	4a. Facility Name (If not institution, give street and number)						4b. City, Tov	vn, or Locat	ion of Death		4c.	County of Dea	ıth			
		ST MARYS HOSPITAL						LEONAL					T MARYS				
		86-84		6. Sex	M 2□F		In yrs. last	birthday) Yrs.	If Under 1 Y Months D	ays Hou	nder 24 Hrs. urs Min.	8. Date of (Month, Sep 3	Birth Day, Year) • 1960	9. Bir	thplace (State or Fountry) yland		
	10a. State		10b. County	,		1	0c. City, T	own or Lo	ocation						10d. Inside City L		
tor	Mary1	and	St. Ma	ary's			Lexi	ngton	Park						1 🗆 Yes 2		
Director	10e. Stree	et and Nu	mber						10f. Zip Co	de	izen of What C	n of What Country?					
La	2146		eron Cou							20653				SA			
Funeral	11. Marita		aind OFT Man		2. Was Dec	orces?	er in U.S.	13.	Was Decedent If Yes, specify	of Hispanio Cuban, Me	c Origin? (Sp kican, Puerto	pecify Yes or o Rican, etc.)	No-	14. Race - Am- Black, Whi			
<u>ک</u>	3 □ W		ried 2 X Mar 4 Divorced	4	If Yes, G Year or [	2 X No live Dates:			1 ☐ Yes 2 <b>X</b>		cify:			Specify: Wh			
Completed		(Spe	15. Deceder cify only highe			1)	1	(Give	dent's Usual O kind of work d DO NOT use re	one during	most of wor	king	16b. Ki	16b. Kind of Business/Industry			
DMC	Elemen	ntary/Sec	ondary (0-12)		College	(1-4or 5+)			ly Specia				Gove	rnment Co	ntractor		
ø	17. Fathe		(First, Middle,	Last)					-	18. M	lother's Nam	ne (First, Mide	dle, Maiden	Sumame)			
To B		ert Al	llen Matt	tingly	y					S	haron I	ee Nord	strom				
		rmant's N	lame/Relations	ship <i>(Typ</i>	e, Print)			19b. Mailir	ng Address (St	reet and Nu	ımber or Ru	ral Route Nui	nber, City o	or Town, State,	Zip Code)		
	Teres	sa Lyr	nn Mattir	ngly/V	dife				Cameron				Ť				
		Burial 2	☐ Cremation		emovai from	n State	cem	etery, crer	natory or other memorial	of rplace)		Date 2005	20c. Location - City or Town, State				
										Great Mills, Maryland							
	21. Signature of Funeral Service Licensee  22. Name and Address of Facility Mattingley-Gardiner Funeral Home  P. 0. Box 270, Leonardtown, Maryland 20650																
	Immedia disease	t1. Enter ick, or hea te Cause or conditi in death)	art failure. List (Final on	r complie t only one	ations that e cause on Rena	each line.	lure		P. O. I					and 2065	Approximate Interval Betwee Onset and Dea		
xaminer	Immedia disease resulting	te Cause or conditi- in death) ally list cause of inter Und disease of	art failure. List (Final on onditions, erlying injury	a.	Rena  Due to  Reper  Due to  Comp	each line.  1 Fai c (or as a c ction c (or as a c	lure consequent of I	ce of): Renal ce of): 7 Hyp		dying, such	h as cardiac	or respirator	y arrest,		Approximate Interval Between		
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ORIGINAL

			1 - For State Registrar	State of Maryland /	Depa		lealth and N	Mental Hyg		05	16467	
200	Physic /Medi Examii	cal	4a. Facility Name (If not institution, give s	. MUNOZ	HOME		r Location of Death		30 4c. Co	Year 05  Dunty of Death	3. Time of Death 8:50 A M OMERY	
	Funeral Director		5. Social Security Number 6. Sex				If Under 24 Hrs. Hours Min.		3	O Diet	place (State or Foreign intry) Cemala	
	should be filed within 72 hours after death with the Maryland nd Mental Hyglene. I marked other than "natural", or items 23s or 28s-f show umatic event. If a Medical Eventher must be notified at	Director	10a. State 10b. County	George's		ation attsvill 10f. Zip Code 2078			10g. Citizer	10d. Inside 1 ☐ Ye Citizen of What Country? USA		
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryian Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show min piury for other traumatic event. The Medical Examinet must be notified at once.	Completed by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1			lispanic Origin? (Span, Mexican, Puerto			Race - Amer Black, White pecify: Whi	, etc.	
Baltimore, Maryland 21215-0036	led within 72 ho lyglene. her than "natuint, the Medical	Completed	15. Decedent's Edui (Specify only highest grade Elementary/Secondary (0-12)		(Give k life. D	ent's Usual Occup ind of work done O NOT use retired emaker	during most of worl		Ow	of Business/l	ndustry	
ıryland	should be fi nd Mental H marked ot! imatic ever	To Be	17. Father's Name (First, Middle, Last) Agustin Comparin  19a. Informant's Name/Relationship (Ty)		Db. Mailing	Address (Street		icia Men	egazz			
iore, Ma	ges 1 and 2 at of Health ar if item 27 is of other trau		Edgar O. Munoz/ St  20a. Method of Disposition  1 **Burial 2 Cremation 3 CR	ep-son 1 20b. Place cemen	2105 of Disposi ery, cremi	Maychec ition (Name of atory or other place	k Lane, E	Bowie, M	D 207			
Baltim	permit, Pa Departmen Important: any injury once.		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service License		F22	ven Cemete Name and Addre ancis J. O Univer	ssetFacility SSCOTTINS	Funeral	Home	Inc	ng,Maryland ,MD 20901	
	Physician /Medical Examiner		23a. Parf I. Enter the disease, or complishock, or hear failure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused the death. Doe e cause on each line.  Pneumo  Due to (or as a consequence	nia		g, such as cardiac	or respiratory arr	est,		Approximate Interval Between Onset and Death UNKNOW	
8760,	cate be executed physician and the burial-transit	Completed by Physician/Medical Examiner	Sequentially list conditions, if any, learning to infine date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Oue to (or as a consequence							1)	
P.O. Box 6	ath certifi ttending or use as		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	Bc. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown		Ectopic pregnancy Other <i>(specify)</i>			23d.	. Date of deliv	ery Day Year	
Records, P	w requires that the de been signed by the a should be detached f		Part II. Other significant conditions con  Cerebro vas a		derlying cause giv	en in Part I.		obacco use contribute to the cause of death?				
	i: The law ก icate has be r, page 2 sh		Dementia G-tube fe	eding				24a. Was a autops perform	y -			
Division of Vital	To the Hospital or Attending Physician: The Is within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page a	ation; To Be	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation		Time of Injury	28c. Injun Worl	er: 4 Nursing Ho	ee of Death (Check only one)  Fursing Home 5 Residence 6 Other (Specify)  28d. Describe how injury occurred				
Divis	pital or Atte ours after de srai Directo illed in by th	i Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, f building, etc. (Specify)				City or Town	n (Street and Number or Rural Route Number, Town, State)			
	o the Hosi vithin 24 ho o the Fune completely f	Medical	29a. Certifler (Check only one)  Certifying Phys	icien: To the best of my knowledger: On the basis of examination at and manner stated.	e, death ond/or inve	estigation, in my of	oinion, death occur	red at the time, da	ate and pla	d manner as sice, and due to gned (Month,	the cause(s)	
	6		30. Name and address of person who cor  NURUL CHOWDHU.	npleted cause of death (Item 23a)	(Type, Pr	D43	121					
	Sta Registr		NURUL CHOWDHU.  31. Date filed (Month Day, Year)  MAY 0 2 20	RY, MD; 5/4/ 32. gistrar's Signature	KIN Marie	G CHAR	LLES WA	7,1367	HESD	IA I M	ישטעניי	

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			For State Registrar	State of	Maryland /		artment rtificate				_	giene Reg. No	005	15	468
			1. Decedent's Name (First, Midd	dle, Last)							2. Date of De Month	eath Day	Year	3. Tim	e of Death
	Physici /Medic		Francis	G. Mc	Grath						April	29	2005	10	:35 P <sup>M</sup>
	Examir		4a. Facility Name (If not institution	on, give street and numb	oer)		4b. City, To	wn, or l	Location of	of Death		4c. (	County of Dear	th	
			Kline Hospice	House			Moun							erick	
	Funeral		5. Social Security Number	6. Sex 7. 1 ☑ M 2 ☐ F	Age (In yrs. last b		If Under 1 Months   E	Year Days	If Under :	Min.	8. Date of Bir (Month, Da	ay, Year)	9. Bir	hplace (Sta	ate or Foreign
	Director		126-28-3531	180 M ZUP	68	Yrs.					July 2	5, 19	36 Nev	√ Ýorl	
	p .		Usual Residence of Decedent 10a. State 10b. Count	h.	10c. City, Toy	vn or L	ocation							10d Incid	e City Limits
	aryla shov	_	Toa. State	,											res 2 No
	8a-1	ctc		derick	Mo	nro									
	or 2	Director	10e. Street and Number				10f. Zip Ci					-	en of What Co	,	
	ath v	rai	12504 Wolf De			71			1770	. 0.40	7 17		ited St		
	tems tems	une	11. Marital Status	12. Was Decede Armed Force	es?	13.	Was Deceden If Yes, specify	nt of His Cuban	spanic Orig n, Mexican	gin? (Spec n, Puerto R	offy Yes or No lican, etc.)	0-	<ol> <li>Race - Ame Black, Whit</li> </ol>		٦,
36	s afte	by Funerai	1 ☐ Never Married 2 🔼 Ma 3 ☐ Widowed 4 ☐ Divorce	If Yes Give		-	1 ☐ Yes 2 🛭	No	Specify:				Specify: V	Mite	
5-0036	72 hours atter death with the Maryland natural', or items 23a or 28a-f show diest Exercites could be medified at	D D				Daca	dent's Usual (	Occupat	tion			16b Kin	d of Business	Industry	
5	"na"	Completed	(Specify only high	ent's Education lest grade completed)		(Give	kind of work of DO NOT use	done du retired)	uring most	t of workin	g	100. Kill	d of business	moustry	
2121	withi	Ē	Elementary/Secondary (0-12)	College (1-4			stigat					TT C	Gover	nmont	
	Hygir ther int, I		17. Father's Name (First, Middle	<u> </u>		TIIVE	SLIgat		18. Mothe	er's Name	(First, Middle			menc	
an	d be intai ed o	Be	Francis H. Mc						шо	lon C	lancy				
Z	2 should be filed within 72 hours and Mental Hygiene. Is marked other then "natural", raumatic event, I's Medical Exu	L <sub>O</sub>	19a. Informant's Name/Relation		19	b Maili	ng Address (S	Street au				er. City or	Town, State, 2	Zip Code)	
Maryland	교통하루		Norelaine McGr										aryland		0
	1 and 2 Health tem 27		20a. Method of Disposition	atii / wire	20b. Place	of Dispo	sition (Name	of			ate est		ation - City or		
٥	ages nt of :: If it		1 Burial 2 Cremation		ate	-	matory`or othe		"   1	May 2 200		17 1	1.	M 1	- 1
Baltimore,	rtmer rtant njury		' 4 ☐ Donation 5 ☐ Other (		Frede		Crema  Name and						erick,		
Bal	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		1	916		8	E. Rid	lgev	ille	Blvd	. Mt.	Airy	al Hom	1and	21771
			23a. Part1. Enter the disease, shock, or heart failure. Lis	or complications that cau st only one cause on eac	ised the death. Do th line.	not en	ter the mode of	of dying	, such as	cardiac or	respiratory a	rrest,			Between
	Physician		Immediate Cause (Final disease or condition  Hepatic Encophal putting										Onset and Death		
	/Medical		resulting in death)	Due to (or	as a consequence	of):	17.00		0					- 3	
п	Examiner	ner	Sequentially list conditions,	b. CIC	ohsis a	4 +1	سو لـ در	181						24	RACS
	D ==		cause. Enter Underlying Cause (Disease or injury	Due to (or	Due to (or as a consequence of):										
	ate be executed hysician and the burial-transit	Examiner	Cause (Disease or injury that initiated events c. resulting in death) Last  Due to (or as a consequence of):												
, 0	ie exe		1630 ting in adding East	Due to (or	as a consequence	01):									
8760,	ate b hysic the b	lica		d	· · · · · · · · · · · · · · · · · · ·								ĺ		
9	leath certificate be executed attending physician and I for use as the burial-transi	Physician/Medical	IF FEMALE:	22- 11											
Вох	death ce le attend ed for us	lan/	23b. Was decedent pregnant in the past 12 months?		h 2 Fetal deat		Ectopic preg					23	3d. Date of del Month	delivery Day Year	
	0 0 0	Sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregnan 9□Unknow	nt at time of death m	5 L	Other (spec	ify)						-	
P.0	res that the designed by the a	Phy	Part II. Other significant condit	tione contribution to don	th but not requiting	in the u	ndarking cau	en aiua	n in Part I		23a Did t	obacco us	e contribute to	the cause	of death?
	signe d be d	by	h is two	at s ) cal	able Ex	_	, ,	so givei			1 🗆				Dunknown
0.0	w require been sli should b	ted	113.01	01 01-01											
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II.  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II.  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II.  Par									24a. Was auto	igs available of cause of					
- H	The law cate has page 2	Con	TurceII	Orghete:	>						1 Yes	ormed?	death?	2□ No	
ita	Physicien: Th this certificate ral director, pag	Be (	25. Was case referred to medic examiner?					7		of Death	(Check only	one)	,		- 200
of V	S S D	2	1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inp		utpatier	nt 3□ DOA	Other	r. 4 □ Nu				Other (Spe	city) Ho	spece
0	ding PI h. After ti funera		27. Manner of Death 1 ☐ Natural 5 ☐ Pend	28a. Date of (Month,	Injury 28b. Day Year)	Time o	f 28c	. Injury Work	at ?	28	8d. Describe	how injury	occurred		
0	Attending r death. octor: After by the fune	atio	2 Accident inves	tigation			М	1 🗀 Y	es 2 🗆 l	No					
Division	r Att	Certification:	3 Suicide 6 Could 4 Homicide deter	mined 280. Place of	f Injury - At home, f , etc. <i>(Specify)</i>	arm, st	eet, factory, o	office		28	Bf. Location ( City or To	Street and wn, State)	Number or Ru	iral Route N	lumber,
	ital or saf														
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medicai		ring Physician: To the basi at Examiner: On the basi and manne	is of examination a										se(s)
	To th Fo th comp	Me	29b. Signature and title of certific	ier			29c. L	icense	number	1 (2			signed (Monti		r)
			manches.	Mren, M	)		D	4	624	18		5	02/0	かど	
	Š		30. Name and address of person	n who completed cause	of death (Item 23a)	(Туре,	Print)		_		- 1				
	10		300 m	1ex 90 5	treet,	1~	solering	h, 1	90	Z 17	71				
	Sta Registr		31. Date filed (Month, Day, Yea	3 2005	istrar's Signature	A	Sept.								

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death . Decedent's Name (First, Middle, Last) 2.7 2.7 APRIL 2005 **Physician** 6:26 P KATHRYN MYERS /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner FREDERICK FREDERICK FREDERICK MEMORIAL HOSPITAL If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** Days Months 1 M 2 PF 220-34-707 Director TUME FREDERICK MS. Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10b County 10a, State 28a-f show other treumatic event, the Medical Examiner must be notified at HOWARD 1 ☐Yes 2 ☐ No md. Director 10g. Citizen of What Country? 10e. Street and Number 10. Zip Code or Items 23e or S.A death by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after conent of Health and Mental Hygiene. Int: If item 27 is marked other then "netural", or Iter 1 □ Never Married 2 □ Married RLACK Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: 3 Widowed 4 □ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOUSE WIFE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) hur LIATALIE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (T ...., Print) (DAUGHTER) 1140 ShAFFERSVIllERd. MT AIRY Department of Health a Importent: if item 27 is eny injury or other tree once. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 5-2-05 SIMDSON U.H.C. CEM. \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility GARCIL. ROlling FRANCHOME 21. Signature of Funeral Service Licensee allino 110 W. South FRED. MO. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPSIS Pnysician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Siecasa of a july that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed burial-transi Due to (or as a consequence of): the attending physician Box 68760 Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) P.0. 9 Unknown 9 Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ PULMON ARY CHRONIC OBSTRUCTIVE 1 Yes 2 No 3 Frobably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 2 🗆 No 2 No 1 Yes the Hospitel or Attending Physician: hin 24 hours after death. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient P 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Aatural 1 ☐ Yes 2 ☐ No 2 Accident Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funerel L 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of centiles 2-05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MT. CULWELL RONALD MILLER DR. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 3 0 Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 3. Time of Death . Decedent's Name (First, Middle, Last) MAY 1, Vear **Physician** ALFRED NELSON MYERS, JR. 2005 2:15 PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 32 BELLA VITA COURT #3A WESTMINSTER CARROLL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, JUNE 13 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1X M 2□ F VIRGINIA 216-14-8888 81 Yrs Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b County 10a State 28e-f show ust be notified at 1 Xes 2 □ No Completed by Funeral Director MARYLAND CARROLL WESTMINSTER 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code with 32 BELLA VITA CT #3A 21157 UNITED STATES items 23e death Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status other traumatic event, the Medical Examinar filed within 72 hours after 1X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes ŽXNo Specify: Specify: WWII WHITE 3XXWidowed 4 ☐ Divorced neturel', 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) **ESTIMATOR** CONSTRUCTION 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 1 and 2 should be fill Health and Mental H Be ALFRED NELSON MYERS, SR. MARY ELMORE 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 15203 OAK ORCHARD ROAD, DAVID N. MYERS/SON NEW WINDSOR, MD item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 ö X Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 5 Department of Important: If any injury or CREST LAWN MEM GARDENS 5/5/2005 MARRIOTTSVILLE, MD 91 WILLIS ST 22. Name and Address of Facility 21. Signature of Funeral Service Licenses MYERS-DURBORAW FUNERAL HOME, P.A. WESTMINSTER, M 23a. Paul. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician 2 months disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisasson Light) that initiated events resulting in death) Last Due to (or as a consequence of). Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical the IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Dav Year in the past 12 months?
1 Yes 2 No 4 Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Nonknown 24b. Were autopsy findings available prior to completion of cause of death? has page 2 autopsy performed 1 ☐ Yes 2 ☐ No certificate 1 Yes 2 No Division of Vital To the Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ → 10 2 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After 5 Pending investigation 1 Natural 2 No death. 1 Tyes 2 Accident Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 🗀 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined after 4 ☐ Homicide within 24 hours a To the Funeral C 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. icai 29a. Certifier (Check only one) 29c. License number 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifier 52035 2005 WSL Mac INTITOI ell 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BINU T. CHACKO M.D. 291 STONER AVENUE SUITE 203, WESTMINSTER, MD 21157 32. Regi dar's Signature 31. Date filed (Month. State Resur & Sparke Registra

			For 1 _ State	State	of Mai	ryland / [		rtment of H		Mental Hy	/gien	е	
			State     Registrar  1. Decedent's Name (First, Middle,	Lacti			Cer	tificate of l	Death	D Date of D	Reg. N	00005	11-51-71
	Physici	an								2. Date of D Month	D	ay Year	3. Time bt Death
	/Medic Examin		James Bo Myers  4a. Facility Name (If not institution,		umber)	Ct	r	4b. City, Town, or	Location of Dea	May		01 2005 c. County of Deat	
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	and and		Usual Residence of Decedent  10a. State 10b. County			10c. City, Tow	m or Lo	cation					10d. Inside City Limits
	Mary -f sho	ţō	MD Car	roll		Tan	eyt	own					1 No 2 No
	r 28a	Director	10e. Street and Number					10f. Zip Code			10g. C	itizen of What Co	untry?
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	r dea	Funerai	11. Marital Status	12. Was De	cedent Ev	er in U.S.	13. V	Vas Decedent of H Yes, specify Cuba	ispanic Origin? (	(Specify Yes or Nerto Rican, etc.)	0-	14. Race - Ame Black, White	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-1 show any injury or other traumatic event, the Medical Exaction in mail be cofflied at ODGe.	y F.	1 Never Married 2 Married 3 Widowed 4 Divorced	If Yes, C	2 □ No Give			☐Yes 2☐No	Specify:	orto i noun, otor,		Specify:	White
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	1		23a. Part1. Enter the disease, or o shock, or heart failure. List of	complications that	caused th	he death. Do	not ente	12 Washir er the mode of dyin	g, such as cardi	ac or respiratory	mine errest,	ster, MD	Approximate
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** April 2005 2110 Katherine Barbara Mudry /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Westminster Carroll Carroll Hospital Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Year) May 18 1931 Birthplace (State or Foreign Country)
 NTV 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 □ M 2 DTF NY 73 Yrs. **Director** 107-22-2290 Usuat Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County If item 27 is marked other than "naturel", or items 23a or 28e-f show or other treumatic event, it a Madical Examiner must be notified at 1 ☐ Yes 2 📉 No Director Westminster Carroll 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21157 25 Washington Lane Funeral filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ X o Specify: Specify: White Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) 12 College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be filment of Health and Mental Healt. If item 27 Is marked ot Helen Goercke Nicholas Hartenstein 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 25 Washington Lane Westminster, MD Robert A. Mudry/husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 🔀 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Importent: If any Injury or once. Meadow Branch Cemetery 4/29/2005 Westminster, MD ' 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service License Prints Fifieraty Home and Chapel, P.A. - V-412 Washington Road Westminster, MD 21157 23a. Raft. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) chearic obstructive pulmon my and shage Buch **Physician** /Medical Due to (or as a consequence of). Examiner S-quentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner Physicien: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physician by Physician/Medical the use as I IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant signed by the atten Id be detached for us 3 Ectopic pregnancy Day Year in the past 12 months? Month 5 Cther (specify) 4 Pregnant at time of death 1 🗆 Yes 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 🗆 No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 performe 21 No 1 ☐ Yes 2 🗆 No 1 Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 1 Tes After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: or Attending 1 Natural 2 Accident 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funerel C To the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely and manner stated 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 27/2005 h. Celves in 031660 asmas 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20

DHMH 17 Rev 1/2001

State

Registrar

HOMAS K.

APR 2 9 2005

31. Date filed (Month, Day, Year)

CALVIN III

32. Registrar's Signature

291 STOWER AVENUE

WESTMINSTER MARYLAND

21151

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/Medica		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death	ì	4c. County of Dea	
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tached for use as	ian	in the past 12 months?	1 ☐ Live birth 2 [ 4 ☐ Pregnant at tim	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	Day Year
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0	y P	Part II. Other significant conditions co	ntributing to death but r	not resulting in the u	nderlying cause give	on in Part I.	23e. Did to	bacco use contribute t	o the cause of death?
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plnods	Completed						24a. Wasa		utopsy findings available
page 2	E C						autops	med? death?	completion of cause of
d .		25. Was case referred to medical				26. Place of Deatl		4	s 2□No
S = 1	o Be	eyaminer?	Hospital:	2 ER/Outpatier	ot 3 DOA Othe	ar		ence 6 Other (Spe	acify)
9 = 9	ü	27. Manner of Death	28a. Date of Injury	28b. Time of		4444		ow injury occurred	,,
e funer	atio	1 Accident 5 Pending investigation	(Month, Day Y	ea <i>r)</i> Injury		Yes 2 □ No			
unaral Diractor: sly filled in by the	L	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury building, etc. (	- At home, farm, str	reet, factory, office		28f. Location (Si City or Town	treet and Number or R	Rural Route Number,
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unar ily fill		29a. Certifier 1 Certifying Phy (Check only 21 Medical Exam	sician: To the best of r						s stated.
Τ ω	edicai	one)	and manner state	d.				and place, and du	
complet	2	29b. Signature and title of certifier	Q		29c. License	number	2	29d. Date signed (Mon	
DA		h	ytme		700	77 280		April 28	LOUI
	1	30. Name and address of person who c	ompleted cause of deal	th (Item 23a) (Type,	Print)	Ounte	70.10	April 28,	1502
3		DR. SUN'L GUPT	e 625 1	JENT H	renue	Compe	Circl)	, IND A	
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Registra			M	600					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death April 30, 2005 ear **Physician** Nancy Lou Malloy 10:27 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Garrett Grantsville 174 West Grant Street If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 01-Mar-1943 9. Birthplace (State or Foreign **Funeral** Min. 1 ☐ M 2 💢 F Director 166-34-5841 62 Yrs Pennsylvania Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 7 is marked other than "natural", or itema 23e or 28e-f show traumatic event, the Mcdical Examinar must be notified at 1 Yes 2 □ No Director Maryland Grantsville Garrett 10e. Street and Number 174 West Grant Street 10f. Zip Code 10g, Citizen of What Country? 21536-U.S.A. permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or itema 23e any injury or other traumatic event, the Medical Examine must once. by Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specif White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) ballistics' laboratory unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) **Emogene Baer** Clyde Amold 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 174 West Grant Street Grantsville 21536 Leo Malloy husband Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 8 Burial 2 □ Cremation 3 □ Removal from State 05-May-2005 Pocohontas Pennsylvania Greenville Cemetery <sup>¹</sup> 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 my 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, mock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) archeec **Physician** /Medical Due to (or as a consequence of) Examiner mor Sequentially list conditions, any, leading to intribute, ause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit Due to (or as a co equence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2 ☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ er0 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed2 2 No 2□ No 1 ☐ Yes 1 Tyes or Attending Physician: after death. Director: After this certifica Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 PResidence 6 Other (Specify) 2 No ဂ္ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) filled in by the funeral 27. Manger of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation M 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) and 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Seton Drive Cumberland Med 902 )rie Velandia 31. Date filed (Month, Pay

Registrar

DHMH 17 Rev 1/200

State

Megistrar's Signature

NJM 05-2995 Preston Patterson

est	ion Pat	ter	SON 1 - For Registrar Amended #20	State of Marylar					/ 111	)5	15475
			Decedent's Name (First, Middle, Last,	) _			O Death Lin	2. Date of Deat			3. Time of Death
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	Examin		4a. Fecility Name (If not institution, give				own, or Location of Deal	-	4c. County o		
			5850 Hollyhock P  5. Social Security Number 6. Se		food birdbyloud	If Under 1	ederick Year   If Under 24 Hrs	O Date of Righ		derick	
	Funeral Director			M 2 F 59	Yrs.		Days Hours Min.	8. Date of Birth (Month, Day,	Year)	Country)	e (State or Foreign
			Usuel Residence of Decedent						10		
	arylar show	7	10a. State 10b. County  Md. Freder	ick Fi	ity, Town or Lo					10d.	Inside City Limits 1 ✓ Yes 2 □ No
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	3a or	IDI	10e. Street and Number 5850 Holly	Hock 1	Vace	701. Zip 1	21703		U. S.		
	urs after death with the Marylan al', or Items 23a or 28a-f show Examiner must be notified at	by Funeral Director	11. Marital Status	12. Was Decedent Ever in U Armed Forces?		Was Decede	ent of Hispanic Origin? (S fy Cuban, Mexican, Puer	Specify Yes or No-		- American , White, etc	
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21215-0036	within 72 hours after death with the Maryland ane. than "natural", or Items 23a or 28a-1 show ta Madical Examirat must be notified at		3  Widowed 4 Divorced  15. Decedent's Edu	Year or Dates:	16a Dece	dent's Usual	Occupation		16b. Kind of Bus		
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Maryland	ihould be id Mental marked o matic eve	70	19a. Informant's Name/Relationship (T)			an Address	Beat r		SOWIE Sity or Town 5		odel
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Jre,	of Hear item		20a. Method of Disposition	20b.	Place of Dispo cemetery, crer				20c. Location - C		
Ë	nit. Pages vartment of l ortant: If it injury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ F ☐ Donation 5 ☐ Other (Specify)	Formoval from State	arriec	v Co.	m. May	7, <del>2004</del> 1	FRED,	MO.	
Baltimore,	permit. Pages Department of Important: If i eny injury or o		21. Signature of Funeral Service License	9e	22	Name and	Address of Facility ROLLINS	FUNER	1 L Home		
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Вох	eath certifi attending I for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of	al death 3[	Ectopic pre			23d. Date Mont	of delivery th Da	y Year
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<u>α</u>	es that igned b		Part II. Other significant conditions co.	- A - T			use given in Part I.	23e. Did tob	acco use contril	oute to the c	cause of death?
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of	g Physer this eral di	<del> </del>	27. Manner of Death	28a. Date of Injury	28b. Time o		c. Injury at Work?	28d. Describe ho			scene
ion	ttending I death. ctor: After y the funer	atio	1 Natural 5 Pending investigation	(Month, Day Year)	Injury	М	1 ☐ Yes 2 ☐ No				
Division	l or Attencafter death Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Spec		eet, factory,	office	28f. Location (Str City or Town		r o <i>r Rural R</i> i	oute Number,
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune		29a. Certifier 1 ☐ Certifying Phy	sician: To the best of my kn	owledge death	h accurred o	t the time, date and class	and due to the co	uea/e\ and man	nor as state	nd.
	n 24 hr e Fun letely	edicai		ner: On the basis of examin and manner stated.	ation and/or in	vestigation,	n my opinion, death occ	urred at the time, da	ite and place, ar	nd due to the	e cause(s)
	To th To th comp	Me	29b. Signature and title of certifier	a A -			License number		d. Date signed		y, Year)
			· Calrilla	& Ali			OCME		May, 1,	2005	
	9		30. Name and address of person who co	ompleted cause of death (Ite			twoot Dali	imore Ma	mul and	21201	
	- C1		31. Date filed (Month_Day, Year)	32. Rearstrar's Sign		eim 5	treet, Balt	more, Ma	ryrand	ZIZUI	
	Sta Registi		MAY 0 3	2005	18	doors	-B				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death APRIL 22° **Physician** 2005 RICHARDSON, III ROBERT 11:10 AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Sandy Spring 17716 Norwood Rd, Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct 15,1942 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 ☐ F 62 Director 416-54-6566 Alabama Usual Residence of Decedent death with the Maryland show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD l Hygiene, other than "netural", or Items 23a or 28a-1 sh vent, tha Medical Exartinat Lex multibad Montgomery Sandy Spring Wes 2 No Director 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 17716 Norwood Road 20860 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status filed within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black þ 3 ☐ Widowed ♣ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Cook Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event once. Robert Richardson, II Willie Mae Watkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20874 MD 12900 Churchill Ridge Cir, Germantown, Denita Williams (Daughter) 20b. Place of Disposition (Name of cemetery, prematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurjak 2 Cremation 3 K Removal from State 21.0n Cemetery 4 Donation 5 Other (Specify) 5/1/05 Ramer, AL 21. Signiture of Funeral Service Lice 2. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 46 N. Washington St., Rockville, MD20850 23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death egter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Pnysician Acute My cardial Infarction Immediate /Medical Due to (or as a consequence of): **Examiner** 8 months Coronary Atherosclerosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and the burial-transit Diabetes Mellitus years that initíated events resulting in death) Last Due to (or as a consequence of) Box 68760, Physiclan/Medical use as attending p for use as IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy 1 Live birth 2 ☐ Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) P.O. 1 the ģ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Hypertension Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has e 2 autopsy performed? page 1 🗌 Yes 2 🖳 No Division of Vital Hospitel or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 XResidence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: After 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No hours after death. investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0035045 April 26, 2005 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Philip Henyum. M.D.3416 Olandwood Ct. #204, Olney, MD 20832 31 Date filed (Month, Day, Year) 22. Registrar's Signature State 0 2 2005 Registrar

DHMH 17 Rev 1/2001

	,	per FD May 2, 2005 Please	State of 1	Agrilan	d / Dono	artmont.	of Health	and Ma	ntal Liv	nieno		F.	
		For State Registrar		viai ylai i	•		of Death	1		Reg. No.	C U U	5 16	47
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xamine	er	4a. Facility Name (If not institution, g		ər)			own, or Location	of Death			County of E		
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eral			Sex 7 1 □ M 2 💢 F	Age (In yrs. 1 83	last birthday) Yrs.		Days Hours		Date of Bi Month Di 08/19/	7 (027)		Birthplace (State	
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	Director	Maryland Prince  10e, Street and Number	Georges	DOW	TE	10f. Zip C	Code	-		10g. Citi	izen of Wha	it Country?	
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	ed	15. Decedent's	Education		16a. Deced	dent's Usual	Occupation			16b. Ki		ess/Industry	
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	Ö	17. Father's Name (First, Middle, La	st)		1,		18. Moth	er's Name (	First, Middle	_			
	) Be	William J. McHal					E11e	n Neal	1 Camr	be11			
	은	19a. Informant's Name/Relationship		_	19b. Mailin	a Address (	Street and Numb					te. Zip Code)	
		Judith R. Jenki			1		Calvert						
		20a. Method of Disposition	ns/ Daugh	20h B	llage of Diego	cition (Mame	n of	Dat				y or Town, State	
		1 KBurial 2 Cremation 3		te c	emetery, cren	natory or oth	ner place)	5/03/0,	ā	Wilke	s-Barra	1	
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Tuneral director, page 2	70	1 ☐ Yes 2 → O	Hospital: 1 ☐ Inp.	atient 2	ER/Outpatien	nt 3 DOA	Other:	lursing Home	5 □ Res	idence	6 Other (	(Specity)	
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D		3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		Injury - At he etc. (Specif	ome, farm, str y)	reet, factory.	office	28	f. Location City or To	(Street an own, State	nd Number o	or Rural Route Nu	mber,
Din 62	ertific		Physician: To the be	est of my kno s of examina	owledge, death	h occurred a vestigation, i	it the time, date a in my opinion, de	and place, an	d due to the at the time	cause(s)	and manne d place, and	er as stated. I due to the cause	(s)
letely filled in by the	dical Certification;	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	aminer: On the basi and manner	stated.									
	Medical Certific	(Check only 2 Medical Ex	aminer: On the basi	stated.		29c.	License number			29d. Da	te signed (A	Month, Day, Year)	
	edical	(Check only 2 Medical Ex	aminer: On the basi	stated.		29c.	License number	36		29d. Da	te signed (A	Month, Day, Year)	
	edical	(Check only 2 in Medical Expone)  29b. Signature and title of certifier	aminer: On the basi	Cu	n 22c\ /T		0320	36		7	te signed (M	JUUT	
completely filled in by the fu	edical	(Check only 2 Medical Ex	aminer: On the basi	Cu	n 23a) (Type.		0320	36 Vive	(2	7	te signed (A	JUUT	)

Registrar

			For State Registrar	State of N	Maryland	d / Depa <i>Cei</i>	artment of H tificate of L	lealth a Death	and Me	ental Hyg	giene 2	005	1647
	Dhysici		1. Decedent's Name (First, Middle, Las	")					2	2. Date of Dea Month	Day	Year	3. Time of Death
	Physici /Medic		THOMAS C. R	LEY						PRIL		2005	3:45P.M
	Examin	er	4a. Facility Name (If not institution, give		or)		4b. City, Town, or				4c. County		737
			MEMORIAL HOST  5. Social Security Number 6. Se	PITAL	Age (In yrs. la	ast hirthday)	CUMB E	RLAN		8 Date of Birt		LEGAN	
17	Funeral Director			<b>X</b> M 2□F	65	Yrs.	Months Days	Hours	Min.	B. Date of Birt (Month, Day JUNE 2,	7, Year) 1939	WEST	ecs (State or Foreign try) VIRGINIA
100	70		Usual Residence of Decedent							, OILE 27	1303		
	anylan show d at	_	10a. State 10b. County	_		, Town or Lo						10	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
	8a-1	Director	WV MINERA	L	FC	DRT ASI					10 - 0':1	140	
	with the		10e. Street and Number				10f. Zip Code				10g. Citizen of		try ?
	eath	eral	DAN'S RUN ROAD	12. Was Deceder	nt Ever in U.S	S. 13.1	26719 Was Decedent of Hi		gin? (Spec	ifv Yes or No	U.S.Z	A • ce - Americ	an Indian.
	r Item	Funeral	1 ☐ Never Married 2 🕅 Married	Armed Force 1 ☐ Yes 2 [	s?	1	Was Decedent of Hi f Yes, specify Cuba		, Puèrto Ri	ican, etc.)	Bla	ick, White,	
ğ	Eren	þ	3 Widowed 4 Divorced	If Yes, Give Year or Date:	s:		1□Yes 21XINo	Specify:			Specia	fy: WH]	ITE
215-0036	72 hc 'natu	Completed	15. Decedent's Ed (Specify only highest grad			(Give	tent's Usual Occupa	during most	t of working	g	16b. Kind of E		•
	Mithin Inen Inen	d I	Elementary/Secondary (0-12)	College (1-4c	or 5+)		DO NOT use retired JCK DRIVE				COMPA	IDT BA	AKING
2	be filed within 72 hours after death with the Maryland ital Hygiene. id other then "natural", or iteme 23a or 28a-f show other then "natural", or iteme 23a or 28a-f show event, the Medical Exerciper must be motified at	ပ္	12 17. Father's Name (First, Middle, Last)			110	JCK DKIVE		r's Name (	(First, Middle,	Maiden Sumai		
an	ag la b	o Be	ROBERT RILEY					HEL		ARIE	SPENCE		
Maryland 21		۲	19a. Informant's Name/Relationship (7	ype, Print)		19b. Mailir	ng Address (Street a	and Numbe	r or Rural	Route Numbe	r, City or Town	, State, Zip	Code)
ž	and 2 alth a 27 ls		CAROLYN KAY RILE	y / WIFE		P.0	о. вох 33	2, FO	RT AS	SHBY, W	w 267	19	
altimore,	00		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from Sta	re	lace of Dispo	sition (Name of natory or other plac	(8)	Da	ite	20c. Location	- City or To	wn, State
Ĕ	Pages ment of ant: If Its ury or o	h J	*4 □Donation 5 □ Other (Specify				BY CEMETE		4/27/	/2005	FORT	ASHBY	, WV
Balt	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licen	1 -6	/	22	. Name and Address UPCHURCH	ss of Facility FUNE	RAL H	HOME, I	NC.		
	707 e a	2 7	23a. Part1. Enter the disease, or comp	uperu		1	P.O. BOX	1260	, FOF	RT ASHE	BY, WV	26719	
н			shock, or heart failure. List only a limmediate Cause (Final	one cause on each	line.	,		,	4		rest,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a			- CVGSC	lun	aza	re			1 month
	Examiner		No.	Due to (or a	as a consequ	Jence ot):							
		er	S - yientially list conditions if any, leading to immediate cause. Enter Underlying	Due to (or	as a consequ	uence oi):							
	cuted nd ransit	Examiner	Cause (Disease or injury that initiated events	С.									
Ö,	ate be executed thysicien and the burial-transit	Ex	resulting in death) Last	Due to (or	as a consequ	uence of):							
8760,	The law requires thet the death certificate be executed to has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	dical		d									
9 ×	eath certific attending pl	Physician/Me	IF FEMALE:	23c. If yes, outcon	ne of pregna	ncv					024 D	-14	
Вох	atten for u	clan	in the past 12 months?	1□Live birth 4□Pregnant	2 Fetal	death 3	Ectopic pregnancy Other (specify)					ate of delive onth	ry D <i>a</i> y Year
о. О	thet the de ned by the a detached f	ysi	1  Yes 2  No 9  Unknown	9□ Unknown									
	s thet ned b	by Pi	Part II. Other significant conditions of	entributing to death	but not resu	ulting in the u	nderlying cause give	en in Part I.		23e. Did to	obacco use con	tribute to th	e cause of death?
ğ	w requires the been signed b should be det									101	∕es 2□No	3 Prob	ably 4 Donknown
Records,	has be	Completed								24a. Was		Were autop	osy findings available
ř		E O									rmed? ? No	death?	2 No
ita	ysician: The lis certificate hadirector, page	Be (	25. Was case referred to medical examiner?						of Death	(Check only o	-		
5	Physic this c	၉	1 1 105 2 M 140	Hospital: 1 Inpa		ER/Outpatier		4 140	-		dence 6 □Ot		9
Division of Vital	ding f	lou	27. Manner of Death  1. Natural 5 Pending 2 Accident investigation	28a. Date of Ir (Month, I	Day Year)	28b. Time of Injury	Work	yat k? Yes 2 ∐ I		sa. Describe r	now injury occu	tied.	
<u> S</u>	Attending Physician: r death. ector: After this certification of the funeral director, I	fica	3 Suicide 6 Could not be	28e. Place of	Injury - At ho	me, farm, str	eet, factory, office			8f. Location (5	Street and Num	ber or Rura	I Route Number,
á	i Diffe	Certification:	4 Homicide	building,	etc. (Specify	()				City or Tov	vn, State)		
	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral		29a. Certifier 1 Certifying Rh	sician: To the be	st of my know	wiedge, deat	occurred at the tin	ne, date an	d place, ar	nd due to the	cause(s) and m	anner as st	ated.
	To the Ho within 24 To the Fu	Medical	one)	and manner	stated.	non and/or in			ar occurred				
ì	To the within To the comple	Σ	29b. Signature and title of certifier	1. //			29c. Licens		,		29d. Date signi	ed (Month, )	مسم
,	5		-	100/	, , , , , , , , , , , , ,			3676	00		11/1/		103
1	iks		30. Name and address of person who	completed cause of	or death (Item	23a) (Type,	Print)	/~	111	MA	2150	2-	
	Sta	te	31. Date filed (Month, Day, Year)	32. Regi	strar's Signal	ture	21 1009	1	Very	1111	7.70		
	Regist		MAY 0 2 2005	Alexander	de	Loon	ري						

Amended Items 4A,10A,17,19A,19B Per F.D. 05/09/2005 Carroll County am Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Year Albert Stone April 30, 2005 1:30 a /Medical 4a. Easility Name (If not institution, give street and number)
2310 Harvey Gummel Road 4c. County of Death 4b. City, Town, or Location of Death Examiner Hampstead Carroll If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Jun 19, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**⋈** M 2□ F Months Days Hours Min 212-22-2721 78 Yrs. Director Maryland Usual Residence of Decedent Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ar than "natural", or itama 23a or 28e-f show The Medical Examinar must be notified at Hampstead 1 ☐ Yes 2 XNo Directo Maryland Carroll the 10e. **2**r2e2a3d Number 10f. Zip Code 10g. Citizen of What Country? 2219 Harvey Gummel Road 21074 USA daath Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: WWII 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pagas 1 and 2 should be filad within 72 hours affar c Depertment of Health and Mental Hygiena. Important: If frem 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Examinant 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: white Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) during most of working Dept of Elementary/Secondary (0-12) College (1-4or 5+) Procurement Manager Natural Resources 12 17. Father's Name God distrone 18. Mother's Name (First, Middle, Maiden Surname) Be Albert Stone, Sr. Fay Younkins 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. In Dorothy Rytine hip Bank Sint) Stone 2219 Harvey Gummel Road, Hampstead, MD 21074 Peggy B. Stone, wife 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 05/02/2005 Carroll Cremations Hampstead, MD ^ 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature a Fundral Service Licensee 22. Name and Address of Facility Eline Funeral Home 934 South Main St, Hampstead, MD 21074 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ears disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, day leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine cartificata has baan signad by tha attanding physician and riractor, paga 2 should ba datachad for usa as tha burial-transit Hospital or Attanding Physician: The law requires that the death cartificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 4☐Pregnant at time of death 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 21 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA Aftar thi 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation daath. al Diractor: A М 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours efter within 24 hours of To the Funaral Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner as stated.

| Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of -29c. License number 29d. Date signed (Month, Day, Year) 0073165 0

名- Charged いんハひ Stg しんいりいし Division of Vital Records, P.O. Box 68760. WIL

10 tiVA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) escu 31. Date filed (Month, Day, Year)

MAY 0 2

2005

32. Registrar's Signature

State

Registrar

Director

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 00 35 Wright Smoot 05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Keninsula Regional Medical Willmill II Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min. Months Days Hours 1 □ M 2 🗷 F 25 212-04-7648 8/24/1979 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Director Maryland Wicomico Willards 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7361 Canal St. 21874 USA Be Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Bace - American Indian. 11. Marital Status Black, White, etc. ☐ Yes 2 Yes, Give 1 Never Married 2 Married 2 🔀 No 1 ☐ Yes 2X No Specify: white 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clothing/apparel 12 Retail Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Gregory A. Wright Lisa Pilchard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeffrey Ryan Smoot/husband 7361 Canal St., Willards, MD 21874 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 MBurial 2 □ Cremation 3 □ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Powellville Cemetery 5/4/05 Powellville, MD 21. Signature of Funeral Service Aconsee 22. Name and Address of Facility Holloway Funeral Home Professional Association Cell aleree 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 19makoma Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4□Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? monas 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4- ☐Unknown Phermonia distresi 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy 2. No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 🗷 No 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. 28d. Describe how injury occurred Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide

72 hours after death with the Maryland 28a-f show traumatic avant, the Medical Examinatmust be notified at or Itams 23a natural al Hygiene. Maryland and Mental F 1 and 2 should be if itam 27 l othar ltimore, Pages permit. Page Department of Important: If any Injury or once. Injury or **Physician** /Medical **Examiner** or Attanding Physician: The law requires that the death certificate be executed burial-transit attending physician Division of Vital Records, P.O. Box 68760 the jo detached þe page 2 should director, filled in by the funeral : After after death. within 24 hours a To the Funaral I To the Hospital text Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier ical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ACOS9368 who completed cause of death (Item 23a) (Type, Print 160 e. Carroll St Salishum 110 distrar's Signature 31. Date filed (Month State 3 2005 Registrar

DHMH 17 Rev 1/2001

n	end item #5 per 1. Decedent's Name (First, Mide	r in	<u>g843_5/1</u>	9/05	JHOE	unca	e or L	Jeani	l a Do	te of Deat	eg. No.	<i>J</i> U	3. Time of Death
-1	Ear1	ule, Last)							Mo	onth	Day	Year	
al -	4a Facility Name (If not institution	on dive s	Hull		Sturg	es_	4	b. City, Town, o	Ap I	of Death	4c. County		10:45PM
er											,		
	Brookegrove 1  5. Social Security Number	6. Sex		e (In yrs. la:	st birthday)		r 1 Year	Sandy S If Under 24 H		te of Birth onth, Day,	Mon	tgomer 9. Birthpla	<b>y</b> ce (State or Foreign y)
	045 07 1459		<b>t</b> M 2□F	94	Yrs.	Months	Days	Hours M			1910		ecticut
-	Usual Residence of Decedent  10a. State 10b. Count	h.		10c City	Town or Lo	ration							d. Inside City Limits
5		•	no <del>T</del> w									100	1 ☐ Yes 2 🔼 No
Director		ntgor	шегу	Sand	y Spr:		. 0 - 1 -					17	
	10e. Street and Number					10t. ZI	p Code			10	Og. Citizen of \	what Country	y?
Funeral	18131 Slade So			E'- 11 6	40.1		2086		(0 · · · · !f · M·			SA	Ladian
إجّ	11. Marital Status		2. Was Decedent I Armed Forces? 1 \( \text{Yes} \) 2 \( \text{P} \)	Ever in U,S.	13. V	Yes, spe	cify Cuba	ispanic Origin? n, Mexican, Pu	erto Rican,	etc.)	Blace	ce - Americar ck, White, et	C.
by F	1 Never Married 2 Ma 3 Awidowed 4 Divorce		If Yes, Give Year or Dates:	NO	1	☐ Yes	<b>⊉</b> No	Specify:			Specify	v: Wh	ite
g	15. Decede		ation		16a. Deced	ent's Usu	al Occupa	ation during most of w	vorking	1	16b. Kind of B	usiness/Indu	stry
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Completed	12 17. Father's Name (First, Middle	( act)				Self	Emp1	oyed	lama (First	Middle N	Paintir Maiden Suman	ig Con	tractor -
To Be										.madio, IV		/	
-	John Sturges  19a. Informant's Name/Relation		oe, Print)		19b. Mailin	g Addres	s (Street a	Ella and Number or		e Number.	City or Town.	State, Zip C	ode)
	Robert H. Stu						1	n Drive					,
+	20a. Method of Disposition	-600	, 501	20b. Pla	ce of Dispos	sition (Na	me of		Date		20c. Location -		
	1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (		emoval from State					θ)	1.100	105		7	
-	21. Signature of Funeral Service		e	St M	ary Ce	Name a	nd Addres	ss of Facility H	4/28	P1-0	Ridgefi 144 Eur	tera,	CT
	Bure	Kd	110	la .									поше D 20904
$\dashv$	23a Part1. Enter the disease, of	or complic	ations that caused	the death.									Approximate
	shock, or heart failure. Lis	st only on	e cause on each iir	ie.									ritérval Between Onset and Death
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ğ	resulting in death) Last		1	Due to (or a	s a consequ	ience of):						1	
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S	Part II. Other significant condit	ions cont	induting to death bu	ut not resulti	ng m the un	uerlying	Jause give	эни гап I.	2.	30. Dia toi 1 🗆 Ye	_	ntribute to t 3 □ Proba	
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y Phy										la. Was ar		24b. Were	autopsy findings able prior to
2									24				
2									_ 24	perform	ieu ?	comp of de	pletion of cause
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o Be Compieted by	25. Was case referred to medic examiner? 1 ☐ Yes 2 ★ No		ospital: 1	nt 2□EF	R/Outpatien	: 3□D	OA Othe	ar.	eath (Ched	perform 1 □ Ye	s 2ANo	of de	pletion of cause eath?
To Be Compieted by	examiner? 1 ☐ Yes 2 ★ No 27. Manner of Death	H	1 L Inpatie		8b. Time of		OA Othe	er: 4 Nursing	eath (Chec	perform 1 □ Ye ck only one □ Reside	s 2 <b>A</b> No	composition of de	pletion of cause eath?
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death PATRICIA AGNES SMITH 0553 A M APRIL 27 20025 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death MONTGOMERY WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK, MARYLAND | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Sept. 15,1951 5 Social Security Number 7. Age (In yrs. last birthday) 6 Sax 9. Birthplace (State or Foreign Guyana Guyana 1 ☐ M 2 🖫 F 53 577-13-0194 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits Hyattsville 1X Yes 2 □ No MD Prince Georges 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 7906 Riggs Road 20783 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 No Specify: 3 N Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home House Keeper 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Agnes A. Bass Francis Logan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) 7906 Riggs Road, Hyattsville, MD 20783 Debbie Smith (Daughter) 20b. Place of Disposition (Name of cemetery crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Gartle of HEAVEN Cem 5/3/05 Silver Spring, MD ' 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Snowden Funeral Home, P.A. 21. Signati re of Funeral Service Lizen 246 N. Wash. St., Rockville, MD 20850 23a. Part1. Enter the disease, or complications that caused the death. 💯 not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) METASTATIL BREAST CANCER TEN YEARS Due to (or as a consequence of): ONE WEEK SEPSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? No 3 Probably 4 Unknown 1 ☐ Yes

Pnysician /Medical Examiner

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page 2 certificate

funeral

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To the Hospitel

**Physician** 

/Medical

Examiner

**Funeral** 

Director

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27 Is marked other

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Pages 1 and 2 should be timent of Health and Mental and mit: If item 27 Is marked lant; or other traumatic evices.

permit. Page Department o Important: If any injury or

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Director

Funeral

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Be Completed

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with the Maryland

hours after death

filed within 72 Hygiene.

Baltimore, Maryland 21215-0036

Examiner that initiated events resulting in death) Last Physician/Medical IF FEMALE

in the past 12 months?

24a. Was an autopsy performe

25. Was case referred to medical examiner?

1 Yes 26. Place of Death (Check only one) 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

1 ☐ Yes 2 No

Hospital: 1 → opatient 2 □ ER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

27. Manner of Death 1 Natural 2 Accident 3 Suicide

4 Homicide

5 Pending investigation 6 Could not be determined

30. Name and address of pe son who completed cause of death (Item 23a) (Type, Print)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

29a. Certifier

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Silver Spring, MARKLAND 20903

29b. Signature and Atlered conflict

29c. License number D61007 29d. Date signed (Month, Day, Year) APRIL 27 2005

KENNETH KHANDAGLE 31. Date filed (Month, Day, Year)

0 2 2005

32. Registrar's Signature

DHMH 17 Rev 1/2001

**ORIGINAL** 

831 E. University Blvd #25

		ı	7 State Registrar		State	of Mary	land / Depa <i>Ce</i>	artment of I rtificate of		ind M	lental Hy	giene Reg. No.					
			Decedent's Name	(First, Middle	, Last)						2. Date of De	ath 🖒	.UUJ	3. Time of Death			
	Physici		Walter Roy	z Seelia							Month April 2	Day 9, 200		9:45 a. M			
>	/Medio		4a. Facility Name (If		give street and r	umber)		4b. City, Town,	or Location of	f Death	14111 2		County of De				
	<u> </u>		Shady Gro	ve Adven	tist Hospi	tal		Rockville	2			Mon	ntgomery				
	Funera!		5. Social Security N		6. Sex		yrs. last birthday)	If Under 1 Year	If Under		8. Date of Bi	rth	9. Bi	irthplace (State or Foreign			
	Director		100-14-5929	9	1∏M 2□F		85 Yrs.	Months Days	Hours	Min.	Nov. 14			Country) w York			
	p _		Usual Residence of	Decedent													
	show show	_	10a. State	10b. County			c. City, Town or Lo	ocation						10d. Inside City Limits			
	Ba-f.	cto	Maryland	Montga	nery		Potomac							1 □Yes XX No			
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	De filed within 72 hours after death with the Maryland hat Hygiene. Ale Hygiene. Ad other than "netural", or flems 23a or 28a-f show event, the Medical Examinar must be notified at	rai	8909 Victor	ry Lane				20854				U.S.A	۸.				
	lems lems	Funeral	11. Marital Status		Armed	cedent Ever Forces?	r in U.S. 13.	Was Decedent of If Yes, specify Cut	Hispanic Orig an, Mexican	gin? (Sp. , Puerto	ecify Yes or No Rican, etc.)	0- 1	<ol> <li>Race - Am Black, Wh</li> </ol>	nerican Indian, iite, etc.			
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Dallillore,	permit. Pages Department of I Important: If its any injuryer of		21. Signature of Fu	neral Service I	Ful	~		2. Name and Addr 00 Univers									
			23a. Part1. Enter the shock, or bear	ne disease, or	complications tha	t caused the	death. Do not en	er the mode of dy	ng, such as	cardiac (	or respiratory a	ırrest,		Approximate Interval Between			
	ากงร์เร่าสก		Immediate Cause (	Final		1).								Onset and Death			
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		Med	IF FEMALE:														
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	by the air	Sic	1 ☐ Yes 2 ☐ 9 ☐ Unknown		4 ☐ Pre 9 ☐ Uni	gnant at time known	of death 5	Other (specify) _					WOTET	Day Tour			
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ń	igne bed	b	Part II. Other signifi	icant conditio	ns contributing to	death but no	ot resulting in the u	nderlying cause gi	ven in Part I.				_	to the cause of death?			
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	Attending ir death. ector: Afte by the fune	ertification;	2 Accident	investig	ation			M 1	Yes 2□	No							
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	vithin 2 To the Complet	Me	29b. Signature and	title of certifier				29c. Licen	se number			29d. Date	e signed (Mor	nth, Day, Year)			
			1	$\overline{}$				86	1817			An	/ 29, :	2005			
	12		30. Name and addre	ess of person	who completed ca	use of death	(Item 23a) (Type,					· yes					
			Shahyar G				edical Cen		Rockvil	le, l	Maryland	20850	)				
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<b>7</b> 5			1 - State Amend Item 4a	State of Marylar -b per me G84				Mental Hygi	•	5 1548	
>	Physici /Medic Examin	cal	1. Decedent's Name <i>(First, Middle, Last)</i> Bertha	Lois		Sweeney		2. Date of Death Month 4-29-05	n Day Year	2050pm <sup>™</sup>	
	Funeral Director		213-04-2107	7. Age (In yrs.	last birthday) 17 Yrs.	Thurmoni	If Under 24 H	s. 8. Date of Birth	Frederic Year) 9. Bi 1957 Mag	k nthplace (State or Foreign country) ryland	
	e Maryland 8a-f ahow	ctor	Usual Residence of Decedent  10a. State  Maryland  Trederi		ty, Town or Lo Thurmo					10d. Inside City Limits 1 ☐ Yes 2 🔯 No	
	is 23a or 21	Funeral Director	10e. Street and Number 11430 Hessong Bri	dge Road	15 12 1	10f. Zip Code	21 <b>7</b> 88		U.S.A	•	
9800	within 72 hours after death with the Maryland ane. than 'natural', or Itams 23a or 28a-f ahow ta Modical Exartinetr ast be notified at	by	11. Marital Status  1 □ Never Married 2 □ X Married  3 □ Widowed 4 □ Divorced	Amed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	'	f Yes, specify Cub		Specify Yes or No- rto Rican, etc.)	Black, Wh		
Maryland 21215-0036	TO 5 5 50	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation a completed) Coilege (1-4or 5+)	(Give	dent's Usual Occu kind of work done DO NOT use retire ity Insp	i during most of w ad)	orking	Factory		
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CON Place of Disposition (Name of								Road, Thu	urmont, MI	21788 r Town, State	
Baltin	permit. Pages 1 Department of H Important: If its any injury or ot once.		*4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Liense	P.A. Fund	eral Home						
	Physician /Medical		23a. Parti. Enter the disease, or complished, or heart allure. List only or immediate Cause (Final disease or condition resulting in death)	ne cause on enten line.	Levi	er the mode of dy	ing, such as cardi	ac or respiratory arre	ege	Approximate Interval Between Onset and Death	
8760,	cate be executed by yes the burial-transit or the burial-transit o	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or as a consequence).							
P.O. Box 68	death certiff le attending ad for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d	ıl death 3 [	Ectopic pregnance Other (specify)	÷у		23d. Date of de Month	olivery Day Year	
ecords, P.	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions cor	tributing to death but not res	sulting in the u	nderlying cause gr	ven in Part I.	23e. Did tob		o the cause of death? robably 4 Unknown	
$\mathbf{\Xi}$	The ate has page	Completed							ed? prior to death?	utopsy findings available completion of cause of	
Division of Vital	To the Hospital or Attending Physician: 1 within 24 hours after death.  To the Funaral Director: After this certifical completely filled in by the funeral director, po	Certification; To Be	25. Was case referred to medical examiner?  10 Yes 2 No  27. Manner of Death 11 Natural 5 Pending investigation 3 Suicide 6 Could not be determined	1   Inpatient 2   28a. Date of Injury (Month, Day Year)   28e. Place of Injury - At h. building, etc. (Specif	ER/Outpatien 28b. Time of Injury ome, farm, str	28c. Inju Wo M 1	her: 4 🗆 Nursing	28d. Describe how	nce 6 V Other (Spe w injury occurred eet and Number or F	ecify)At scene	
_	tha Hospital hin 24 hours a the Funaral i mpletely filled	Medical Co	29a. Certifier (Check only one)	sician: To the best of my knoner: On the basis of examina and manner stated.	owledge, death	n occurred at the ti vestigation, in my	ime, date and plac opinion, death occ	e, and due to the car curred at the time, da	use(s) and manner a te and place, and du	s stated. e to the cause(s)	
ļ		×	29b. Signator and title of certifier	mo		29c. Licen			d. Date signed <i>(Mon</i> oril 30, 2		
	Sta	ite	30. Name and address of person who co	mpleted cause of death (Item 2005 32. Resistrar's Signa		111 Per	nn Stree	t Baltimor	e, Maryla	nd 21201	
	Registr		MAI U O	TOOL STREET	State of	greed)					

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year James Leo Spencer, Jr. April 23, 2005 4:15 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Beverly Health Care Frederick Frederick | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. Birthplace (St. Months | Days | Hours | Min. | March | 11,1922 | Maryland 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 **□X**M 2 □ F 212-16-4368 83 Yrs. Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "naturel", or items 23a or 28e-f show the Medical Exercines cast be notified at Maryland Mt. Airy 1 ☐ Yes 21 No Funeral Director Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13862A Old National Pike 21771 United States 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Track Foreman B&O Railroad Ith and Mental Hygie 27 is marked other r treumatic event, II 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be nent of Health and Mental nt: If item 27 is marked o James Leo Spencer, Sr. Beatrice Dorsey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hester Thompson/ Daughter 1602 Jennings Ct., Frederick, MD 21702 other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 5 1 ⊠Burial 2 □ Cremation 3 □ Removal from State permit. Page Department o Importent: If 4/29/2005 Frederick, Maryland Resthaven injury ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityStauffer Funeral Home, P.A. 'n Budles 1621 Opossumtown, Pike, Frederick, MD 21702 23a. Part 1. Enter the risk ase, or com fications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart in ure. List only the cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) METASTATIC **Physician** Colon /Medical Due to (or as a consequence of): Examiner 1E TASTATIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence or). Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician by Physician/Medical the for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 should be 3 Probably 4 Dunknown 1 ☐ Yes 2 ☐ No Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? page certificate 1 Yes 2 No 1 ☐ Yes 20 No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t To the Hospitel or Attending 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours To the Funerel 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medicai (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature as title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Doo 47951 X 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AVE . FREDERIUL. 814 TOLL HOUSE MD >IBTE A. KAZMI, HO 31. Date filed (Month, 32. P gistrar's Signature State 3 2005 Registrar

		For State Registrar	State of Ma	aryland / l	-	tment of H ificate of I		Mental Hy	giene Reg. No. 2	005	161.
Q .		1. Decedent's Name (First, Middle, Last	)					2. Date of De	eath Day	Year	3. Time of Deat
Physici /Medic		Marilyn B. Sh	arp						29, 200		0605
Examin		4a. Facility Name (If not institution, give	,			4b. City, Town, or	Location of Dea	th	4c. Coun	ty of Death	
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Funeral		5. Social Security Number 6. Se	x 7. Age ∃M 2⊠F	e (In yrs. last bir	irthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	. (Month, Da	ay, Year)	9. Birth	place (State or Form
Director		219-28-1379 Local Residence of Decedent		72	115.			May 16	, 1932	Mar	yland
M H		10a. State 10b. County		10c. City, Tow	vn or Loca	ition					10d. Inside City Lin
de de	ğ	Maryland Carro	11			Ha	mpstead				1 ☐ Yes 2√2
128e	rec	10e. Street and Number		I		10f. Zip Code	,		10g. Citizen of	What Cou	intry?
Hygiene. ther then "neturel", or Items 23e or 28e-f show ont, the Medical Examinar must be multified at	Funeral Director	2736 Old Ft. Sch	oolhouse	Road			21074			US	SA.
S E	ner	11. Marital Status	12. Was Decedent ! Armed Forces?	Ever in U.S.	13. Wa	as Decedent of H	ispanic Origin? (	Specify Yes or No to Rican, etc.)	)- 14. Ra	ice - Ameri ack, White	can Indian,
or Its	F	1 Never Married 2 Married	1 ☐ Yes 2 ☑ N	No		SS, specify Cube	Specify:	to riloan, etc.)	Spec		
LEAS	d by	3	Year or Dates:		-						vhite
neti	Completed	15. Decedent's Ede (Specify only highest grad	ication le completed)	16a.	i. Decedei (Give kii	nt's Usual Occupand of work done	ation during most of wo l)	orking	16b. Kind of	Business/Ir	ndustry
then	m d	Elementary/Secondary (0-12)	College (1-4or 5	i+)	ille. DÇ	Ministe:				Church	n
Hygiene kther the ant, lite		17. Father's Name (First, Middle, Last)				12112000		me (First, Middle	. Maiden Suma	ıme)	
ed o	To Be	Milton Bennett						v Feezer		<b>-</b> /	
and Mental Is marked of sumatic eve	F	19a. Informant's Name/Relationship (T	vpe, Print)	196	b. Mailing	Address (Street a	a common to	ural Route Numb		n, State, Zij	o Code)
ealth ar n 27 Is ier treu		Michele Jeffrey,			-			ad, Tane			
f Health item 27 other tr		20a. Method of Disposition		20b. Place of	of Disposit	ion (Name of tory or other place		Date	20c. Location		
nent of h ant: If ite ury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ f  ' 4 ☐ Donation 5 ☐ Other (Specify,	Removal from State	1	-	Cemeter		02/2005	Syke	evill	le, MD
된 변경		21. Signature of Funeral Service Licens				Name and Addres			Funeral		
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1		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused	the death. Do							Approximate Interval Between
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Medical		disease or condition resulting in death)	a Due to (or as	a consequence	of):	Seps	->			-	79312
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atten for u	lan	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal death		ctopic pregnancy other (specify)				ate of delivionth	ery Day Year
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signed by the attending physician i be detached for use as the buria	/Ph	Part II. Other significant conditions co	ntributing to death b	ut not resulting in	in the und	erlying cause give	en in Part I.	23e. Did t	obacco use cor	tribute to t	he cause of death?
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been si	Completed							24a. Was	an 24h	Were auto	ppsy findings availa
page 2	m							auto	psy prmed?	prior to co death?	mpletion of cause
certificate rector, pag		25. Was case referred to medical		·			OF Place of Do	1 Yes	2 II No	1 🗆 Yes	2□ No
this certificaral director,	o Be	ayaminer?	Hospital: 1 ☐ Inpatie	nt 2□ER/Ou	utnationt	3□ DOA Othe	ar _/	ath <i>(Check only c</i> Home 5 🗌 Resi		hor (Chasii	6.1
h. After this funeral c	Η.	27. Manner of Death	28a. Date of Injur	ry 28b. 1	Time of	28c. Injury	at		how injury occu		(9)
r death. ector: After by the funera	ig l	1 Natural 5 Pending 2 Accident investigation	(Month, Day	/ Year) 1	Injury	Work M 1 □ '	<br Yes 2 □ No				
after death.  Director: A I in by the fu	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju	ury - At home, fa	arm, stree	t, factory, office				ber or Rura	al Route Number,
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within 24 hours after deatl  To the Funerel Director: completely filled in by the	edical	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam)	sician: To the best oner: On the basis of	of my knowledge	e, death o	ccurred at the tim	e, date and plac	e, and due to the	cause(s) and m	anner as s	itated.
the F	Medi	one)	and manner sta	ited.							
T Co.	~	29b. Signature and title of certifier	Jame (	Vselw	2	29c. License		_	29d. Date sign		
150			1 7	- 1,2			0005994	>	April	791	2005
10		30. Name and address of person who co	mpleted cause of d	eath (Item 23a)	(Type, Pr	int)	<b>N</b>	1 4 100 -	10 × AA 10	7 7	157
		31. Date filed (Month, Day, Year)		ar's Signature	iA. ,	2016	ئى يارى	JIMIN S	Les 1415	1	31
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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April **Physician** 27 2005 9:55 P M Charlotte Sullivan /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Arnold Future Care Chesapeake Anne Arundel If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5 Social Security Number 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year **Funeral** Months Days Hours 1 □ M 2 🕅 F Yrs June 6, 1920 Director 212-18-5615 84 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 27 is marked other than "natural", or items 23a or 28a-1 show traumatic event, it e M. Alcal Examinar must be notified at Maryland Anne Arundel Annapolis 1 ☐ Yes 2X No Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 954 Highpoint Drive 21401 U.S.A. Completed by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2KNo If Yes, Give Year or Dates: Specify: Specify. White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within; the and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Nurse Nursina 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) John Elmer Stokes Slydelia Harrison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health an Charlotte Elsey/daughter 954 Highpoint Drive 21401 Annapolis, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 7 ₩₩Burial 2 ☐ Cremation 3 ☐ Removal from State ŏ permit. Page Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Cedar Bluff Cemetery 5/2/2005 Annapolis, Maryland 21. Signature Frune I Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to him ediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner the burial-transit certificate be executed Due to (or as attending physician for use as the burial Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) \_ P.O. the 9☐ Unknown 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3□ DOA this 28c. Injury at Work? 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After t 1 Natural
2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No after death. the 3 🗌 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 5 Hospital 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier (Check only one) and manner stated within 2 To the To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 31. Date filed (Month, Day, Year) State Registrar

1			State of Maryland / De 1- State UNpend Item 23a, pt.II, 27 per	partment of Health and Mental Hygiene
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	Physici	an	1. Decedent's Name (First, Middle, Last)	2. Date of Death  Month  Day  Year  3. Time of Death
>	/Media		Sterling Lacy Sanford  4a. Facility Name (If not institution, give street and number)	May 8, 2005 7:06 P  4b. City, Town, or Location of Death  4c. County of Death
	Examir	ıęr	Maryland General Hospital	Baltimore
7	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	
	Director		578-64-9620 1X□M 2□F 56 Yrs.	09/13/1948 Virginia
8	land ow		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or	Location 10d. Inside City Limits
	Mary Ff sh	to	Maryland Anne Arundel Laurel	1 ☐ Yes 2 [No
	or 288	Director	10e. Street and Number	10f. Zip Code 10g. Citizen of What Country?
	ath wi		3226 Orient Fishtail Road	20724 USA
	er de:	Funeral	Armed Forces?	Was Decedent of Hispanic Origin? (Specify Yes or No- lf Yes, specify Cuban, Mexican, Puerto Rican, etc.)     14. Race - American Indian, Black, White, etc.
336	urs aft	by F	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: 167-170	1 ☐ Yes 2 █XNo Specify: Specify: Black
21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. od other than "naturat", or itams 23e or 28e-f show event. The Medical Eraminer must be rectified at	ted	15. Decedent's Education 16a. Dec	cedent's Usual Occupation 16b. Kind of Business/Industry
21	- 174	Completed	(Specify only highest grade completed) (Gillementary/Secondary (0-12) College (1-4or 5+)	ive kind of work done during most of working a. DO NOT use retired)  United States Government
72	filed w Hygiei othar tl		2 Comp.  17. Father's Name (First, Middle, Last)	uter Specialist Smithsonian  18. Mother's Name (First, Middle, Maiden Sumame)
and	ould be f Mental H arked of	o Be	Johnny Edward Sanford	Gertrude Reed
Maryland	s 1 and 2 should be filed within f Health and Mental Hygiene. item 27 is marked othar than othar traumatic evant, the M	10		ailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
	12 mg		Paulette L. Sanford/ Wife 3226	Orient Fishtail Road Bowie, MD 20724
Baltimore,	iges 1 an nt of Heal If itam 2 or other		1 E-Burial 2 Compation 2 Democrat from State cemetery, or	sposition (Name of Date 20c. Location - City or Town, State rematory or other place)
Ë	Pages tment of I tant: If it jury or o		'4 Donation 5 □ Other (Specify)  Maryland  Memorial	National 5/16/2005 Laurel, MD
Bal	permit. Pages Department of Important: If I any Injury or once.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Robert E. Evans Funeral Home
			23a. Part1. Enter the disease, or complications that caused the death. Do not e	16000 Annapolis Road Bowie, MD 20715  enter the mode of dying, such as cardiac or respiratory arrest,  Approximate
	Enysician		shock, or heart failure. List only one cause on each line.	Interval Between Onset and Death
	/Medical		disease or condition resulting in death)  a. Complications of Virus or Tarke components.	Liver Cirrhosis due to Hepatitis C
	Examiner		Sequentially list conditions, b.	
	ed sit	ine	Tarly leading to immediate cause. Enter Underlying Cause, Disease or injury	
	execut and al-trar	Examiner	that initiated events resulting in death) Last	
8760	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	ical	d	
9	rtificat ng phy as th	Medi	IF FEMALE:	
Вох	eath certific attending p	lan/	23b. Was decedent pregnant in the past 12 months?	3 Ectopic pregnancy Month Day Year
0.	at the de by the a rtached f	Physiclan/Med	1 Yes 2 No 4 Pregnant at time of death 5	5 Other (specify)
<u>α</u>	that the poly		Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?
Records,	w requires been signi should be	ed by	Status Post Liver Transplantation	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown
900	e taw re has bee je 2 sho	Completed		24a. Was an autopsy findings available prior to completion of cause of
Œ.		mo C		performed? death?  1☑ Yes 2 □ No 1 ☑ Yes 2 □ No
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?  Hospital: 35.	26. Place of Death (Check only one)
of	Phys this ral dii	٦.	TK Tes 2 No TEMPatient 2 EH/Outpati	
	Attanding I r death. ector: After by the funer	tlon	27. Manner of Death  1 X Natural 5 Pending 2 Accident Investigation  28a. Date of Injury (Month, Day Year)  28b. Time Injury	
Division	Attandi er death. ector: A by the fu	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, so building, etc. (Specify)	street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State)
Ö	spital or Attand		Building, etc. (apacity)	Sity of Town, States
	a Hospital 24 hours a a Funaral I letely filled	edical	29a. Certifier  (Check only one)  1□ Certifying Physician: To the best of my knowledge, der (Check only one)  Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, and due to the cause(s) and manner as stated. investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
	To tha Hosi within 24 ho To tha Funa completely f	Me	29b. Signature and title of certifier	29c. License number 29d. Date signed (Month, Day, Year)
	, ,,,		Hota - Ulmin - Holla	OCME May 10, 2005
			30 Name and address of person who completed cause of death (Item 23a) (Typi	e, Print)
			TATRICIA ATOTICA-TOLOKINO	111 Penn Street Baltimore, Maryland 21201
97	Sta Registr		31. Date filed (Month, Day, Year)  32. Significant Signature	Small o
		12	100000	

				partment of Health and Me Pertificate of Death	ental Hygiei Reg.	
	Physici /Medic Examin	al	1. Decedent's Name (First, Middle, Last)  HAROLD JEFFREY STEVENS  4a. Facility Name (If not institution, give street and number)  SACCED HOART HOSDITAL	4b. City, Town, or Location of Death	01 3	Day Year 3. Time of Death 3. 18 A.M. 4c. County of Death
I	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda $218-70-1967$ Usual Residence of Decedent	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye) MAY 9,195	
	he Maryland 8a-1 show olified at	Director	10a. State         10b. County         10c. City, Town or           MD         ALLEGANY         CUMBERI	AND		10d. Inside City Limits 1 XYes 2 □ No
9036	72 hours after death with the Maryland natural", or Itams 23a or 28a-1 show dical Examinat must be notified at	by Funeral	10e. Street and Number  600 GREENE STREET  11. Marital Status  1 X Never Married 2□ Married 3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 X No If Yes, Give Year or Dates:	10f. Zip Code  21502  3. Was Decedent of Hispanic Origin? (Specif Yes, specify Cuban, Mexican, Puerto R  1 □ Yes 2 ▼ No Specify:		Citizen of What Country?  U.S.A.  14. Race - American Indian, Black, White, etc.  Specify: WHITE
121215-0036	d within jiene. r than "	Completed	(Specify only highest grade completed) (Gi   Elementary/Secondary (0-12)   College (1-4or 5+)	redent's Usual Occupation re kind of work done during most of working DO NOT use retired)  NAGER  18. Mother's Name (	g	TIRE SERVICE
Maryland	a d a d d d	To Be	JAMES HAROLD STEVENS	ELEANOR illing Address (Street and Number or Rural	IRENE	LANTZ
Baltimore, M	ss 1 and of Health item 27 r othar tr		20a. Method of Disposition 1 □ Burial 2X Cremation 3 □ Removal from State  20b. Place of Discemetery, completely,	O. BOX 4161 - WINCH position (Name of ematory or other place)  ND CREMATORY  O. BOX 4161 - WINCH  Da  04/28/2  04/26/	005 20c.	A 22604  Location - City or Town, State  CUMBERLAND, MD
Balt	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee  23a. Part 1. Enter the disease, or complications that caused the death. Do not eshock, or heart failure. List only one cause on each line.	22. Name and Address of Facility UPCHURCH FUNERAL, H 202 GREENE STREET,	IOME, P.A CUMBERL	•
8760,	/Medical examiner // // // // // // // // // // // // //	lical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):	culsur bleen	5€	Interval Between Onset and Death
.O. Box 6	death certifii e attending p id for use as	Physician/Medical		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
ords, P	w requires that the been signed by th should be detache		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		co use contribute to the cause of death? 2 🖼 o 3 🗆 Probably 4 🗇 Unknown
Vital Records,	The law ate has b page 2 st	Completed by	Bourenemia		24a. Was an autopsy performed	
of	ding Phys n. After this funeral di	ertification; To Be	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death 1  Accident investigation  1  Accident   1  Acciden	of 28c. Injury at 28		6 ☐Other (Specify) njury occurred
Division	Hospital or Attend 24 hours after deatl Funaral Diractor: stely filled in by the	0	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, building, etc. (Specify)		City or Town, St	
	To tha Hos within 24 hc To tha Fun completely i	Medical	29a. Certifier  (Check only one)  1 ★ Certifying Physician: To the best of my knowledge, de 2 ★ Medical Examiner: On the basis of examination and/or and manner stated.  29b. Signature and title of certifier	29c. License number	d at the time, date a	and place, and due to the cause(s)  Date signed (Month, Day, Year)
)	3		30. Name and address of person who completed use of death (Item 23a) (Typ	D3(575	4	MD 21509
ł	アん Sta Registr		DR Robert Well K 902 Set 31. Date filed (Month, Day, Year) APR 2 8 2005	on Drive, Cumb	erland,	MD 21502

	,		State of M	aryland		nent of H		nd Men		iene2 0 0 5	16491
			Decedent's Name (First, Middle, Last)						Date of Death		3. Time of Death
	Physici /Medic		BRENDA JEAN SHANHOLT	3					May	1 200	5 1805 M
2	Examin	er	4a. Facility Name (If not institution, give street and number		4b.	City, Town, or	Location of	Death	1	4c. County of Dea	ath (
			5. Social Security Number 6. Sex 7. A	SPITO ge (In yrs. lasi	t birthday) If I	Inder 1 Year	If Under 2		Date of Birth	FIITGO	ing
	Funeral Director		234-76-1779	99 ( <i>mi yis. iasi</i> 58	Mo	nths Days	Hours	Min.	Month, Day,	,1946 WES	rthplace (State or Foreign ountry) TVIRGINIA
			Usual Residence of Decedent					100	31. 30,	/1310   NEC	VIROINIZI
	nylan show		10a. State 10b. County		Fown or Location	1					10d. Inside City Limits
	Sa-1 s	Director	MD ALLEGANY	FRC	STBURG						Y Yes 2 No
	72 hours after death with the Maryland naturel', or Itams 23a or 28a-f show JIGH Exertituat be notified at	Die	10e. Street and Number  187 E. MAIN STREET		10	f. Zip Code 21532			10	og. Citizen of What C U.S.A.	ountry?
	eath is 23,	Funeral	11. Marital Status 12. Was Deceden	Ever in II S	13 Was I		spanic Orig	in? (Specify	Yes or No-	14. Race - Am	erican Indian
<b>'</b>	fter d	F	Amed Forces  1 Never Married 2 Married 1 Yes 37  If Yes, Give	?		Decedent of Hi., specify Cubar	n, Mexican,	Puerto Rica	in, etc.)	Black, Wh	
036	72 hours after dea "natural", or Itams edical Exercitment	by	3 ☐ Widowed 4 🌠 Divorced If Yes, Give Year or Dates:		1 🗆 Y	es 🎾 No	Specify:			Specify: V	WHITE
5-0	fwithin 72 ho piene. r than "natur the Medical I	Completed	15. Decedent's Education (Specify only highest grade completed)	1	16a. Decedent's (Give kind	of work done a	lurina most	of working	1	6b. Kind of Business	s/Industry
121	within lene. than "	Idm	Elementary/Secondary (0-12) College (1-4or	5+)	life. DO N	OT use retired,	) -			HOME	
22			12 17. Father's Name (First, Middle, Last)		HOMEN	IAKER	18 Mother	's Name (Fir	rst Middle M	HOME faiden Sumame)	
an	be it d	To Be	EUGENE W. SMITH					DA M.		, , , , , , , , , , , , , , , , , , , ,	
Maryland 21215-0036	d 2 should but and Menta 7 Is markad traumatic even	1		.,	19b. Mailing Ad	dress (Street a				City or Town, State,	Zip Code)
	nd 2 lith a 27 Is r tra		19a. Informant's Name/Relationship (Type, Print) COMPANIO MICHAEL E. JONES / COMPANIO	HON-	187 E	. MAIN	STRE	ET, FR	ROSTBUE	RG, MD 21	.532
altimore,	ges 1 and t of Healt if item 2: or other		20a. Method of Disposition  1 Burial 2 Commation 3 Removal from State		e of Disposition	(Name of y or other place	9)	Date	2	Oc. Location - City o	Town, State
Ĕ	Pages ment of I ant: If it ury or o	- /	'4 □ Donation 5 □ Other (Specify)	CUME	BERLAND	CREMAT	ORY 0!	5/03/2	2005	CUMBERLA	ND, MD
Balt	permit. Pag Department Important: I eny injury o		21. Signature of Funeral Sovice Licenson		22. Nar UE	ne and Addres CHURCH	s of Facility FUNE	RAL HO	ME, P.	.А.	
	<u></u>		TOTORO HI LEPCHUN	2/	20	2 GREE	NE STI	REET,	CUMBER	RLAND, MD	21502
			23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each	line.				cardiac or res	spiratory arre	st,	Approximate Interval Between Onset and Death
	Pnysician /Medical	1	Immediate Cause (Final disease or condition resulting in death)	cinom	a of +	he Kio	Lney				3 months
	Examiner		Due to (or a	a consequer	nce of):		6				
		آو ا	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury)	s a consequer	nce of):						
	uted	Examine	cause. Enter Underlying Gause (Disease or injury that initiated events  c.								
o,	be executed sician and buriat-transit			s a consequer	nce of):						
8760,	ate be hysici the bu	Physician/Medical	d								
9	eath certific attending p for use as f	/Mec	IF FEMALE: 230 If was outcome	o of programs		-					
Вох	ath c attend for us	lan/	23b. Was decedent pregnant in the past 12 months?	2 Fetal de	ath 3 □Ecto	pic pregnancy or (specify)				23d. Date of de Month	Day Year
o.	at the de by the tached	yslo	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	it time or deat	3 3	si (specily)					
<b>Q</b>	g g g	by Pł	Part II. Other significant conditions contributing to death	but not resultii	ng in the underly	ring cause give	n in Part I.		23e. Did toba	acco use contribute t	o the cause of death?
rds	w requires been sign should be	ed b	Cachexia, Severe a	nemia				_	1 Yes	s 2 □ No 3 □ P	robably 4 Unknown
of Vital Records,	aw re	Completed	·						24a. Was an autopsy		utopsy findings available completion of cause of
Ä	The fav	ĕ							perform	ed? death?	
/ita	Physicien: 1 this certificat ral director, p	Be (	25. Was case referred to medical examiner?				26. Place	of Death (Ch	neck only one	)	
of \	Physic this c	은	1 ☐ Yes 2 ☑ No Hospital: 1☐ Inpat			DOA Othe	4 [] Nut:			nce 6 Other (Spe	ecify)
		lon	27. Manner of Death 1 Natural 5 □ Pending (Month, D	ay Year)	Bb. Time of Injury	28c. Injury Work	at :? /es 2.⊟N		Describe how	w injury occurred	
Division	I or Attendi after death. Director: A I in by the fu	lical	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Ir	niury - At homo	e, farm, street, f				Location (Stre	eet and Number or F	Tural Route Number.
Div	pital or A ours after eref Directilled in by	Certification;	4 Homicide determined building, e	itc. (Specify)	, ,	,,			City or Town,	State)	
			29a. Certifier  (Check only  2 Medical Examiner: On the basis	of my knowle	edge, death occ	urred at the tim	e, date and	place, and	due to the car	use(s) and manner a	s stated.
	To the Hos within 24 h To the Fur completely	edical	(Check only one) 2 Medical Examiner: On the basis and manner s	of examination tated.	and/or investig	ation, in my op	oinion, death	n occurred a	t the time, da	te and place, and du	e to the cause(s)
	To the within 2 To the complet	2	29b. Signature and title of certifier			29c. License	number	37		d. Date signed (Mon	th, Day, Year)
•	1		Christopher Tagn		)	レン	7171	<i>)</i> (		5/1/05	
	your		30. Name and address of person who complete is use of DR. Christo cher Vaanon i	death (Item 23	3a) (Type, Print)	CO:UP	Cin	nber '	10-20	, ND 215	7
	Sta	ite		trar's Signatur		سررو	0		.5.0 5	د ایم مد	
	Registr		MAY 0 3 2005	· A	Specific.	ė .					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Рм Donald A. Thompson 27, 2005 Apri1 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Atlantic General Hospital Berlin Worcester If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth Month, Day, Year 6/17/1940 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1 ☑ M 2 ☐ F 64 221-26-0893 Delaware Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. fnside City Limits or 28a-f show if of Health and Mental Hygiene.
If item 27 is marked other then "natural", or items 23a or 28a-f ehov or other traumatic event, the Madical Examinate must be notified at 1 ☐ Yes 2 No Directo Delaware Sussex Selbyville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Rd#1 Box 144 Bayville Road Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bfack, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Colfege (1-4or 5+) Jeweler Jewelry Sales Maryland 3 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Peges 1 and 2 should be fi Oppartment of Health and Mental H Important: If Itam 27 is marked of any injury or other traumatic even spice. ould be f Mental I Donald A Thompson Cora Elizabeth Hill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rd#1 Box 144, Selbyville, DE. Imogene M. Thompson/ Wife 19975 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Millsboro Cemetery 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 5/1/05 Millsboro, Delaware 5 Other (Specify) Signature of Funeral Service Licen Melson Funeral Services, Ltd. Thatcher St., Frankford, De. 19945 23a. Part1. Enter the dise le, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failur. List only one cause on each line. Approximate Onset and Death fmmediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed attending physicien and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signe should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No page 2 s certificate has autopsy performed? 1 ☐ Yes 2 ☐ No or Attanding Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes / 2 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA this 27. Mann of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 2 atural Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Diractor: filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide hin 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0444 30/Nam an address of person who completed cause of death (frem 23a) (Type, Print) Corroll Street Shiston 31. Date filed (Month, Day, Year) State MAY 02 Registrar

22 more

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P.O. Box 68760,

Division of Vital Records,

			1 - For State Registrar	State of I	Marylan		artment of F		ind Men	, ,	iene	7	1 2 2 2 2
	Physici /Medic		Decedent's Name (First, Middle, La     HERBERT HAROLD T	- 100						Date of Death Month PRIL	Day	Year 2005	3. Time of Death ()
	Examir		4a. Fecility Name (If not institution, given 125 COURSEY ROAD)				4b. City, Town, o	ILLE			4c. County QUEEN	I ANN	Œ'S
ŀ	Funeral Director			Sex 7. 1 <b>X</b> M 2 □ F	Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	Date of Birth Month, Dey, PT. 17	Year) 7, 1915		plece (State or Foreign htry) RYLAND
	e Maryland Ba-f ehow	Director	10a. State 10b. County  MD QUEEN A	NNE'S		, Town or Lo						1	0d. Inside City Limits 1 ☐ Yes 2 🌠 No
	with the		10e. Street and Number				10f. Zip Code			1	g. Citizen of W	/hat Cour	ntry?
9003	be filed within 72 hours after death with the Maryland ital Hygiene. Ind other than "naturel", or Items 23a or 28a-f ehow avent. The Medical Examinar must be notified at	d by Funeral	125 COURSEY ROAD  11. Marital Status  1 Never Mamed 2 Married  3 Widowed 4 Divorced	12. Was Decede Armed Force 1  Yes, Give Year or Date	s? ₹No		21638 Was Decedent of H f Yes, specify Cuba	Specify:	in? (Specify Puerto Rical	Yes or No- n, etc.)	Specify:	k, White,	ніте
21215-0036	e filed within 72 lat Hygiene. other than "nat	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)		or 5+)	(Give	tent's Usual Occup kind of work done DO NOT use retired	during most	of working		6b. Kind of Bu	siness/Ind	dustry
Maryland 2	should be filed ind Mental Hygi is marked other umatic avent, I	To Be C	17. Father's Name (First, Middle, Last GLENN THOMAS	)					's Name (Fir.	st, Middle, M	laiden Sumame	9)	
Man	0 0 0 0		19a. Informant's Name/Relationship ( ROY CORBMAN/GRAN	**			ng Address (Street COURSEY F					State, Zip 1638	Code)
Baltimore,	Pages 1 and 2 nent of Health int: if Item 27 i		20a. Method of Disposition  1 X Burial 2 Cremation 3 C  4 Donation 5 Other (Special	Removal from Sta	20b. Pl	ace of Dispo	sition (Name of nation or other place MEMORIAL	ce)	Date 4/16/2	2	Oc. Location - (	City or To	own, State
Balti	permit. Pages 1 Department of H Important: If Ite eny injury or ot		21. Signature of Funeral Service Lice	nsee C	ttor	22 <b>F</b>	Name and Address ELLOWS, E	ss of Facility	BEIN &	NEWNA	M FUNE		HOME, P.A.
	Pnysician /Medical		23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that cause one cause on each	wech		er the mode of dyin		cardiac or res	piratory arres	st,	8	Approximate Interval Between the and Death
8760,	rate be executed hysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter this entire Cause (Disease or injury that initiated events resulting in death) Last	b	as a consequ as a consequ as a consequ	ence of):							l
.O. Box 6	that the death certific ed by the attending p detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown	23c. If yes, outcon 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 ☐ Fetal tat time of de	death 3 [	Ectopic pregnancy Other (specify)				23d. Date Mon		ory Day Year
s, D	quires that the signed by all do detaction		Part II. Other significant conditions of	contributing to death	n but not resu	lting in the ur	nderlying cause give	en in Part I.		23e. Did toba			e cause of death?
Vital Record	ysician: The law requires that the is certificate has been signed by the director, page 2 should be detached	Completed								24a. Was an autopsy performe	ed? de	nor to consath?	osy findings available npletion of cause of 2 \( \text{No} \)
Vite Vite	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		-	Othe		of Death (Chi				
Division of	Attending Physic death.  ector: After this by the funeral di	tlon: To	1 Yes 2 No  27. Manner of Death 1 Atural 5 Pending 2 Accident investigation	28a. Date of Ir (Month, L		R/Outpatient 28b. Time of Injury	28c. Injun Work	r at	28d. I		ce 6 Other		")
Divis	i Gift	Certification:	3 Suicide 6 Could not be determined	28e. Place of	Injury - At hor etc. (Specify)	m <b>e, farm, stre</b>	et, factory, office			ocation (Stre City or Town,		r or Rurai	l Route Number,
	he Hospitel in 24 hours a he Funerel i pletely filled	edical	29a. Certifier 1 Certifying Pt (Check only 2 Medical Examone)	nysician: To the be miner: On the basis and manner	of examinati	vledge, death on and/or inv	occurred at the timestigation, in my op	ne, date and pinion, death	place, and d occurred at	ue to the cau the time, dat	ise(s) and man e and place, ar	ner as stand	ated. the cause(s)
)	To the To the Complet	W	29b. Signature and title of certifier	weh			29c License	9 P 88	7	290	d. Date signed	(Manth, L	Day Year)
	COLK		30. Name and address of person who DAVID SMITH, MD.	, 29466 F	INTAII	DRIVI		5, EAS	STON, 1	MD 21	601	55(1	
A.	Sta Registr		31. Date filed (Month, Day Year)	2005 <sup>32. Reg</sup>	rar's Signati		Societe						

DHMH 17 Rev 1/2001

		For State Registrar	State	of Marylar		artment of		nd Mental Hy	giene Reg. No. 2 ()	05	16494			
Physi	cian	1. Decedent's Name (First, Middle	e, Last)					2. Date of De. Month	ath Day	Year	3. Time of Death			
Physic /Med		DIANA	DEE		TOLSO			APRIL	21, 20		10:45 P M			
Exam	iner	4a. Facility Name (If not institution, give street and number)  4b. City					n, or Location of	Death		4c. County of Death  QUEEN ANNE S				
3. A.M.	,	325 KIDWELL AV 5. Social Security Number	ENUE 6. Sex	7. Age (In yrs.	last hirthday)		REVILLE ar If Under 2	4 Hrs. 8 Date of Bir						
Funera Directo		218-48-5260 Usual Residence of Decedent	1 □ M 2 <b>X</b> F	57	Yrs.	Months Da		Min. (Month, Da	y, Year) L, 1947		place (State or Foreign htry) YLAND			
land ow		10a. State 10b. County		10c. C	ity, Town or Lo	ocation		-		1	10d. Inside City Limits			
Mary -1 sh	Ď	MD QUEE	N ANNE'S		CENT	REVILLE					1 XYes 2 No			
be filed within 72 hours after death with the Maryland that Hygiene.  India Hygiene.  od other than "natural", or frems 23s or 28s-f show event, the Medical Experiment must be notified at	Director	10e. Street and Number				10f. Zip Cod	ө		10g. Citizen of \	What Cour	ntry?			
th wit	aiD	325 KIDWELL A	VENUE			216	17		USA					
r dea	Funerai	11. Marital Status	Armed	cedent Ever in U Forces?	J.S. 13.	Was Decedent of	of Hispanic Orig Juban, Mexican,	in? (Specify Yes or No Puerto Rican, etc.)		e - Americk, White,	can Indian, etc.			
or it	by Fu	1 Never Married 2 Marr	If Yes, (	i 2 <b>X</b> No Give		1 ☐ Yes 2 <b>X</b>	No Specify:		Specify	· WH	HITE			
If I I I I I I I I I I I I I I I I I I		3 Widowed 4 Divorced	Year or	Dates:	16a Dece	dent's Usual Oc	cupation		16b. Kind of Br	siness/In	dustry			
n 72	Completed	(Specify only higher	st grade complete		(Give	kind of work do DO NOT use re	ne during most	of working	TOD. KING OF DE	23110334111	addity			
withi iene.	E	Elementary/Secondary (0-12)	College 5	(1-4or 5+)	OFFI	CE PERS	ONNEL		LAW EN	FORC	EMENT			
Hyging other snt, I	0	17. Father's Name (First, Middle,					18. Mother	's Name (First, Middle,	Maiden Suman	18)				
should be fill and Mental H; marked oth	ToB	WILLIAM H.	TOLSON		40h Maili	Addrson /C4		ROTHY LEE	FERRIC		Codel			
2 a a a	1	19a. Informant's Name/Relations		OMILED				or Rural Route Number		State, Zip	Code)			
ire, indiryic		DOROTHY F. THO 20a, Method of Disposition	MPSUN/ M		Place of Dispo	osition (Name of		REVILLE, MI	20c. Location -	City or To	own, State			
) % ° = 5		1 X Burial 2 Cremation			cemetery, cre-	matory`or other,	place)	4-25-2005	CENTREV	-				
Definit. Page: Department o Important: If i		*4 □ Donation 5 □ Other (S 21. Signature of Funeral Service		Pitt			dress of Facility		VIIIII V	-11111	,			
Depara any i	ouce	> Yljemas K	Holle	ulcin	FE 40	LLOWS,H 8 S. LI	ELFENBE BERTY S'	IN & NEWNAM	VILLE. M	L HO	ME, P.A.			
		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	t caused the dea n each line.	ith. Do not en	ter the mode of	dying, such as c	ardiac or respiratory a	rrest,		Approximate Interval Between Onset and Death			
STOU, ate be executed Associate and Associate and be burial-transit	ical Examiner	resulting in death)  Due to (or as a consequence of):  Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):								NE				
that the death certificated by the attending phy detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ♣No 9 □ Unknown	1 Live	outcome of pregress birth 2 Fet legrant at time of known	aldeath 3[	⊒Ectopic pregna ⊒ Other (s <i>pecif</i> y				te of delive	ery Day Year			
	þ	Part II. Other significant conditi	ons contributing to	death but not re	sulting in the t	inderlying cause	given in Part I.		obacco use cont Yes 2 □ No		he cause of death?			
Ords, requires been sign hould be	eted													
ne ha	Completed				· · · · · · · · · · · · · · · · · · ·			24a. Was auto perfo	osy ormed?	were auto prior to co death? 1 □ Yes	opsy findings available impletion of cause of			
VICIAL FILLIANT THE SECTOR, PAGE	a a	25. Was case referred to medical	1				26. Place	of Death (Check only of		1 1 1 1 3	2 110			
69 =	0,0	examiner? 1 Yes 2 No	Hospital: 1 [	☐Inpatient 2	☐ ER/Outpatie	nt 3 DOA	Other: 4 Nur	sing Home 5 🔀 Resi	dence 6 □Oth	er (Specit	(y)			
J O P	tion: T	27. Manner of Death  1 Natural 5 Pending Pendi	ng (M	te of Injury onth, Day Year)	28b. Time of Injury		njury at Work? 1 □ Yes 2 □ N		how injury occur	red				
or A or A of A or A or A	Certification:	2 Accident Investi 3 Suicide 6 Could 4 Homicide determ	not be 28e. Pla	ice of Injury - At I ilding, etc. (Spec				Street and Numb wn, State)	er or Rura	al Route Number,				
5 4 T S	edical (									anner as s and due to	tated. o the cause(s)			
To the Hos within 24 h To the Fur completely	₩.	29b. Signature and title of certifier 29c. License number								d (Month,	Day, Year)			
F > F 0		1 2mic	E. Chr	7 Due	KM.	1) 1	350	48	4/27	1/20	005			
		30. Name and address of person	who completed ca	use of death (Ite	23а) (Туре	Print)	/ /			10				
10 VIL		ERIC R. CIGAN	EK, M.D.,	2540 C	ENTREV	LLE ROA	D, CENT	REVILLE, M	D 21617					
· 5	State strar	31. Date filed (Month, Day, Year,	32 <b>5</b> 2005	. Registrar's Sign		1 .0								

DHMH 17 Rev 1/2001

ORIGINAL

05-02942 OUNG THACH

	_	1 - State Registre MEND#5perINE	5,5/4/05,BM	w <b>,</b> MbCo	Cer	tificate of	Death		Reg. No.		·
hysici		Decedent's Name (First, Middle,     DUNG THACE						2. Date of Dea	28 <sup>Day</sup> 200	5 ear	3. Time of Death 9:48 A M
/Medic Examin		4a. Facility Name (If not institution, SUBURBAN HOSPIT	,	nber)		4b. City, Town, o BETHES		th	4c. County MONTG		7 CO
ineral ector		5. Social Security Number 6	.Sex 1)XIM 2□F	7. Age (In yrs. la	ast birthday) 19 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		/, Year)	9. Birthpi Coun Viet:	lace (State or Foreign try) nam
Mo til		Usual Residence of Decedent  10a. State  10b. County		10c. City	, Town or Lo	cation				10	0d. Inside City Limits
28e-f show	ctor	Md. Montgo	mery		Gaithe	rsburg					1 ☐ Yes 2 📉 No
or 28	Dire	10e. Street and Number	-h 0			10f. Zip Code	2070		10g. Citizen of V		try?
Items 23e	Funeral Director	9002 Bramble Bu	12. Was Dece	dent Ever in U.S	S. 13. V		20879 Ispanic Origin? (	Specify Yes or No- rto Rican, etc.)	Vietnam 14. Race	e · Americ	an Indian,
o 🚆	by	1 Never Married 2 Marrie 3 Widowed 4 Divorced	Armed For 1 Tyes tf Yes, Give Year or Da	2 <b>X</b> ] No e		Yes, specify Cuba	Specify:	rto Rican, etc.)	Specify	k, White, e	
"neturel",	Completed	15. Decedent's (Specify only highest			16a. Deced	lent's Usual Occup kind of work done OO NOT use retired	ation during most of we	orking	16b. Kind of Bu	siness/Inc	lustry
then.	ldmo	Elementary/Secondary (0-12)	College (1	-4or 5+)	Mech.		1)		Automob	ile	
Is marked other then eumatic event, I've M.	Be Co	17. Father's Name (First, Middle, La	est)	I			18. Mother's Na	ame (First, Middle,			
arked atic e	To E	Du Thach					Kim K				
7 Is m treum		19a. Informant's Name/Relationshi Kim Ket (Mother						iural Route Numbe			
itsm 2 other		20a. Method of Disposition		20b. PI	ace of Dispo	STAMDLE sition (Name of patory or other place	Busn Co	urt Gaith Date	20c. Location -		
ant: Fit		1 □ Burial 2 ▼ Cremation 3 `4 □ Donation 5 □ Other (Spe		Jiaio		itan Cren	riav	1,	Alexandı	cia,	Va.
Importent: If itsm 27 any injury or other troones.		21. Signature of Funeral Service Li	cense Du	7					eral Home thersburg, Md. 20877		
attending physician and automoting physician and automoting the purial-transit	edical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or Hijer) that initiated events resulting in death) Last	b	or as a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or	uence of):	<i>\\</i>					
ed by the attending detached for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live b	come of pregnal irth 2 Petal ant at time of de own	death 3	Ectopic pregnancy Other (specify)	,		23d. Dat Moi	e of delive nth	ry Day Year
g e	by	Part II. Other significant condition	s contributing to de	eath but not resu	ulting in the u	nderlying cause giv	en in Part t.			ribute to th 3 □ Prob	e cause of death? ably 4 AUnknown
cate has been si , page 2 should l	Completed							24a. Was autop perfor 1 Yes	sy p	prior to con leath?	osy findings available inpletion of cause of
certificate lirector, pag	o Be	25. Was case referred to medical examiner? 1 X Yes 2 □ No	Hospital:	npatient 2X	ER/Outpatien	t 3 DOA Oth	or	eath (Check only only only only only only only only		er (Snecifi	<i>(</i> )
After this	$\vdash$	27. Manner of Death  1 Natural 5 Pending	28a. Date of	of Injury	28b. Time of	28c. Injur		-	ow injury occurr		J. S
the fu	Certification:	2 Accident investiga 3 Suicide 6 Could no	ition 4 (28)	05	8:54	1 d d d d d d d d d d d d d d d d d d d	Yes 2 No	when	Lace	dt	(David Marchael
Direct In by	erlifi	4 Homicide determin	280. Place	ng, etc. (Specify	me, tarm, str	eet, factory, office		City or Town	m, State)	te Pres	Route Number
To the Funerel Director: A completely filled in by the fa	edical C		Physicien: To the xeminer: On the ba					e, and due to the			
Compl	Me	29b. Signature and title of certifier		, «.		29c. Licens			29d. Date signed		
		Theodore	M X	78 re	Cor	0	CME		APRIL 2	9, 20	)U5
1				16 11 111		0: 0					
1		30. Name and address of person w	*	e of death (item	23a) (Type,	.11 PENN	STREET,	BALTIMOR	E, MARY	LAND.	21201

### APRIL 26 2005 0555  ### EXCITION 49. Facility Name (if not institution, give street and number)  ### April 26 2005 0555  #	Physician			e (First, Middle, La	ist)							2. Date of				3. Time of D	eat
Security Name of not instance; give severe and number)   Security Name of not instance; give severe and number)   Security Name of N	Madical		ERNEST	JOSEPH	WHITE,	JR.										0555	
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The state of the s	Funeral	5										8. Date of (Month,	Birth Day, Year)	) 9	. Birthplace Country)	e (State or	Fore
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150 Decedents Description   150 Decedents	r, or the				1 XYes 2 If Yes, Give	□ No						Rican, etc.)					
Baken Baken	ature cal E	-		15. Decedent's E		7777	16a, Dece	dent's Usua	al Occupa	ition			16b, K	(ind of Busir			
17. Father's Name (Prist, Modife, Astern Sumanne)   17. Father's Nam		-		ify only highest gr	ade completed)	or 5.1	(Give	kind of wor	rk done d	lurina mos	t of work	ing				,	
19. Mailing Address (Streat and Number or Funal Route Number, City or Town, State, Zip Code)	et la			ridary (0°12)	College (174	OI 3+)	BA	KER					E	BAKING			
E. JOSEPH WHITE, III / SON 44.11 GRENWICH COURT, BELLCAMP, MD 21017  20a. Method of Depocition 10 De	vent,	, 1								18. Mothe	er's Name	First, Mid	dle, Maider	Sumame)			
E. JOSEPH WHITE, III / SON 4411 GRENWICH COURT, BELLCAMP, MD 21017  20a. Method of Disposition  20b. Place of Disposition (Name of County)  20c. Location - City or Town, State  20c. Location - City or Location  20c. Location - City or Locatio	atic e		ERNEST	JOSEPH W	HITE, SR.	•				HAZ	ZEL I	DAYTON	<u> </u>				
20b. Place of Design   20b. Coation - City or Town, State   20b. Coation - City or Town, State   20b. Place of Design   20b. Place of Design   20b. Place of Design   20b. Place of Design   20b. Coation - City or Town, State   20b. Coation - City or Town, Cath or Coation	B	1	19a. Informant's Na	ame/Relationship (	(Type, Print)		19b. Maili	ng Address	(Street a	and Numbe	er or Rura	al Route Nu	mber, City o	or Town, Sta	ate, Zip Co	nde)	
1.	01 L	_		-	, III / S					COUF							_
23a. Part. Enter the disease, or comflications that caused the death. Do not enter the mode of dying, such as cardae or respiratory arrest.  Approximate an original resulting in death of the cause of each interest in the cause of each interest in the cause of each interest in the cause of each interest in the cause of each interest in the cause of each interest in the cause of each interest in the cause of each interest in the cause of each in the cause of each interest in the caus	or off	2			☐Removal from Sta	1 00	ace of Dispo emetery, cre	osition (Nam matory or o	ne of ther place	9)	- (	Date	20c. L	ocation - Cit	y or Town,	, State	
23a. Part. Enter sty disease, or complications that caused the death. Do not enter the mode of dying, such as cardae or respiratory arrest.  Approximate and consequence of	ury o		* 4 ☐ Donation	5 ☐ Other (Special	fy)		OKS MI	LL CE	METE	RY 04	1/29/	/2005	S	TRING	TOWN,	PA	
23a. Part. Enter the disease, or comflications that caused the death. Do not enter the mode of dying, such as cardae or respiratory arrest.  Approximate an original resulting in death of the cause of each interest in the cause of each interest in the cause of each interest in the cause of each interest in the cause of each interest in the cause of each interest in the cause of each interest in the cause of each interest in the cause of each in the cause of each interest in the caus	ny in	2	21. Signature of Fu	ineral Service Lice	ns		2:	2. Name and	d Addres	s of Facilit	Y TOAT.	HOME	D A				
23a. Part. Enter #6 disease, or com/dications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and disease, or com/dications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and consequence of the cause (Final Immediate Cause). Immediate Causes (Final	7 - 2 O		YURNA	2 11.0	Mchel	6		202 (	GREE	$NE\_SI$	REE	CUM	BERLA	ND. M	D 21	502	
Immediate Cause (Final desease or condition resulting in death)   Due to (or as a consequence of):	*	1	23a. Part1. Enter til shock, or hea	ne disease, or com rt failure. List only	notications that cau	sed the death	. Do not en	ter the mode	le of dying	g, such as	cardiac o	or respirator	y arrest,				er
Due to (or as a consequence of):  Sequentially list conditions.  Due to (or as a consequence of):  C. Due to (or as a consequence of):  d.  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  C. Due to (or as a consequence of):  Due to (or as a consequ	vsician	Ļ	Immediate Cause (	(Final	Lu	na	00								0-	nset and De	
Sequentially list conditions of more regular to the past 12 months?    FEMALE:   200   Was decedent pregnant in the past 12 months?   1   Leve birth 2   2   Fetal death   2   2   Fetal death   2   2   No. 3   Probably   1   1   Ves. 2   No. 3   Probably   2   No. 3   Probabl	ledical			-	a		1 / 1	nrox	5								٦n
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The state of the s	ner F		Sequentially list cor	nditions		a onsequ		ncer	<u> </u>								n
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	urial-tra	r	nat initiated events	S	b. Due to (or	as a consequ	ence of):	ncer	<b>S</b>								'n
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    239. Did tobacco use contribute to the cause of death   1	hysicia the bur	r	nat initiated events	S	b. Due to (or	as a consequ	ence of):	ncex									n
Part   . Other significant conditions contributing to death but not resulting in the underlying cause given in Part   .	physicia ts the bur edical	r	nat initiated events resulting in death) L	S	b. — Due to (or c. — Due to (or d. —	as a consequ	ience of):	ncev							2		n
The state of the s	physicia ts the bur edical	r	nat initiated events resulting in death) L	Last t pregnant	b. Due to (or  c. Due to (or  d. 23c. If yes, outco	as a consequence as a consequence of pregnar as a 2 pressure as a consequence as a conseque	ience of): ience of): ience of): ience of):	⊒Ectopic pre	egnancy						2 -	mont	
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25. Was case referred to medical examiner?  26. Place of Death (Check only one)  27. Manner of Death  28a. Date of Injury  28b. Time of Injury at Work?  28c. Injury at Work?  2	igned by the attending physicial be detached for use as the but by Physician/Medical	r P	FFEMALE: 23b. Was decedent in the past 12 1	t pregnant months?	b. Due to (or c. Due to (or d. 23c. If yes, outco 1 Live birth 4 Pregnan 9 Unknow	as a consequence of pregnar at time of de	nence of):  sence of):  sence of):  sence of):  sence of):	⊒Ectopic pre	egnancy	on in Part I.		1	id tobacco i	Month use contribu	f delivery Day	y Ye	ar
28a. Date of Injury - At home, farm, street, factory, office  28a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)	s been signed by the attending physicia 2 should be detached for use as the bur 2 should by Physician/Medical	r P	FFEMALE: 23b. Was decedent in the past 12 1	t pregnant months?	b. Due to (or c. Due to (or d. 23c. If yes, outco 1 Live birth 4 Pregnan 9 Unknow	as a consequence of pregnar at time of de	nence of):  sence of):  sence of):  sence of):  sence of):	⊒Ectopic pre	egnancy	n in Part I.		1 24a. W	id tobacco i	Month use contribu  No 3[ 24b. Wer	f delivery Day site to the co	y Ye ause of deay  ###################################	ar ath? kno
27. Manner of Death    Chattural   2   EH/Outpatient   3   DOA   4   Nursing Home   5   Residence   6   Other (Specify)	s been signed by the attending physicial 2 should be detached for use as the bur burded by Physician/Medical	r 2	FFEMALE: 23b. Was decedent in the past 12 1	t pregnant months?	b. Due to (or c. Due to (or d. 23c. If yes, outco 1 Live birth 4 Pregnan 9 Unknow	as a consequence of pregnar at time of de	nence of):  sence of):  sence of):  sence of):  sence of):	⊒Ectopic pre	egnancy	on in Part I.		24a. W	id tobacco i	Month use contribu  No 3[  24b. War prio dea	f delivery Day site to the c. Probably re autopsy r to complet	y Ye  ause of dea  y 🏖 Un  findings aveition of cau	ar ath? kno
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29a. Certifier (Check only one)  29b. Signature and title of certifier  29b. Signature and didress of person who completed cause of death (Item 23a) (Type, Print)  DR.AFAQ AHMAD 625 KENT AVENUE SUITE 102 CUMBERLAND, MARYLAND 21502	this certificate has been signed by the attending physicia director, page 2 should be detached for use as the bur To Be Completed by Physician/Medical	P 2	F FEMALE: 23b. Was decedent in the past 12 1  Yes 2  Use Unknown Part II. Other signif	t pregnant months?	b. Due to (or c. Due to (or d. 23c. If yes, outco 1 Live birth 4 Pregnan 9 Unknow contributing to deat	as a consequence as a consequence of pregnar h 2 Fetal at at time of den	ience of): ience of):	□Ectopic pre □ Other (spe	regnancy recify) ause give	26. Place	of Death	24a. Wate per second of the pe	id tobacco i  Yes 2  as an itopsy enformed? s 22 No	Month use contribu  No 3[ 24b. War prio dea 1 □	f delivery Day site to the co	y Ye  ause of dea  y 🏖 Un  findings aveition of cau	ar ath? kno
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29a. Certifier (Check only one)  29b. Signature and title of certifier  29b. Signature and didress of person who completed cause of death (Item 23a) (Type, Print)  DR.AFAQ AHMAD 625 KENT AVENUE SUITE 102 CUMBERLAND, MARYLAND 21502	ther this certificate has been signed by the attending physicial uneral director, page 2 should be detached for use as the bur and if it is a should be detached for use as the bur in To Be Completed by Physician/Medical	P 2	F FEMALE: 23b. Was decedent in the past 12 1 Yes 2 Unknown 2art II. Other signif	t pregnant months?  No  red to medical  No  b  5 □ Pending investigatio	b. Due to (or c. Due to (or d	me of pregnar h 2 Fetal ht at time of de n th but not resu  patient 2 Elijury Day Year)	ience of): ience of):	□Ectopic pre □ Other (special of special of	egnancy ecify)  ause give	26. Place	of Death	24a. Wall per 1 Yeb of (Check on me 5 R. R. 28d. Describ	id tobacco u  Yes 2  as an itopsy informed? s 22 No	Month use contribu  No 3[ 24b. Wer prio dea 1   6  Other ( ry occurred	f delivery Day site to the complete autopsy or to complete the complet	y Ye  ause of dea  y Hun  findings aveition of cau	ar kno alla
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  DR.AFAQ AHMAD 625 KENT AVENUE SUITE 102 CUMBERLAND, MARYLAND 21502	ther this certificate has been signed by the attending physicial neral director, page 2 should be detached for use as the but are 170 Be Completed by Physician/Medical	P 2	F FEMALE: 23b. Was decedent in the past 12 1  Yes 2  Use year year. 25. Was case refer examiner? 1  Yes 8  Use year. 26. Manner of Deatt Yard Accident 3  Suicide	t pregnant months?  No  red to medical  No  b  5 Pending investigatio 6 Could not b	b. Due to (or c. Due to (or d. 23c. If yes, outco 1 Live birt 4 Pregnan 9 Unknow contributing to deat  Hospital: Inp 28a. Date of (Month,	as a consequence of pregnant 2 Fetal at at time of deministration of the but not result to the but not result	ience of): ience of):	□Ectopic pre □ Other (special of special of	egnancy ecify)  ause give	26. Place	of Death	24a. Wate per 1 1 2 4 a. Wate per 1 2 4 a. Wate	id tobacco or yes 2  The sa an intopsy shrormed?  So 2 No (y one)  asidence  asidence  asidence  asidence	Month use contribu  No 3[  24b. Wer prio dea 1   6   Other ( ry occurred	f delivery Day site to the complete autopsy or to complete the complet	y Ye  ause of dea  y Hun  findings aveition of cau	ar kno- aila se (
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  DR.AFAQ AHMAD 625 KENT AVENUE SUITE 102 CUMBERLAND, MARYLAND 21502	ther this certificate has been signed by the attending physicial process. It is a street but the but affector, page 2 should be detached for use as the but and it is a street or it. To Be Completed by Physician/Medical	P 2	F FEMALE: 23b. Was decedent in the past 12 1  Yes 2  9  Unknown 2art II. Other signif	t pregnant months?  No red to medical No h 5 Pending investigatio 6 Could not b determined	b. Due to (or c. Due to (or d. 23c. If yes, outco 1 Live birt 4 Pregnan 9 Unknow contributing to deat  Hospital: Inp 28a. Date of (Month, n 28e. Place of building	as a consequence of pregnar h 2 Fetal at at time of den not result the but not result to but not resul	ience of): ience of):	□Ectopic pre □ Other (special contents) and arriving calculated arriving calculated and arriving calculated and arriving calculated arriving calculated and arriving calculated arriving calculated arriving calculated and arriving calculated arriving calculated arriving calculated arriving calculated arriving calculated arriving calculated arriving calculated arriving calculated arriving calculated arriving calculated arriving calculated arriving calculated arriving calculated arriving calculated arriving	egnancy ecify)  ause give  ause give  Bc. Injury Work  1 □ Y	26. Piace  1 4 □ Nu 1 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	of Death	24a. Water per 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	id tobacco ( Yes 2  Tas an itopsy strormed?  \$2 No (y one)  ssidence  n (Street art Town, State)	Month use contribu  No 3[  24b. Wer prio dea 1   6   Other ( ry occurred	f delivery Day site to the completion of to completion of the comp	y Ye  vause of deal  y   indings averaged in or cau  No	ar kno
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	Physici	an	1. Decedent's Name (First, Middle, Las	t)							<ol><li>Date of Dea Month</li></ol>	ath Day	Yea	ır	3. Time o	of Death
y	/Medic Examin	al	ROBERT 4a. Facility Name (If not institution, give	RTCHARD street and number)	V	VARI		SR. Town, or	Location o	f Death	APRIL	_ 29		)5	5:10	A
			21820 GLENDALOUG	H ROAD			G	AITH	ERSBU	JRG			MONTGO	)MEI	RY	
	Funeral Director		5. Social Security Number 6. Se		(In yrs. last bii	rthday) Yrs.	If Under Months	1 Year Days	If Under a	Min.	8. Date of Birt (Month, Da Sept.1		9. 6	Birthpla Counti Nev	ace (State ry) W Jer	or Foreign
	and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Tow	n or Lo	ocation								d. Inside C	
	Maryl B-f sho	tor	Md. Montg	omery	Gait	her	rsburg	ſ							1 🗌 Yes	2 X No
	vith the	Funeral Director	10e. Street and Number	a Dood			10f. Zip	Code	200	202		-	zen of What		•	
	sath v	eral	21820 Glendaloug	12. Was Decedent E	ver in II S	13 1	Was Dagad	ent of His		382	city Ves or No.		nited 14. Race - A			
980	72 hours after death with the Maryland "natural", or Itams 23a or 28a-f show dical Examiner must be multipled at	þ	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ☑ Divorced	Armed Forces?  1 X Yes 2 N  If Yes, Give  Year or Dates:		i	Il Yes, spec		Specify:	, Puerto F	cify Yes or No Rican, etc.)		Black, W		tc.	
21215-0036	c * 30	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a	(Give	dent's Usua kind of wor DO NOT us	k done d	urina most	of workir	ng	16b. Ki	nd of Busine	ss/Indi	ustry	
212	ifiled within if Hygiene. other then "rent, I've Mod	omo	Elementary/Secondary (0-12)	College (1-4or 5- 4	-)		tball					S	ports			
	be filed stal Hygi of other avent, I	Be	17. Father's Name (First, Middle, Last)  James Joseph	Ward							(First, Middle,	Maiden	Sumame)			
Maryland	should be ind Mental s marked o umatic ave	<sup>L</sup>	James Joseph  19a. Informant's Name/Relationship (7)	1,100	101	Mailie	na Addrone	/Stroot o	Mai	_	evine Route Numbe	r City o	r Tour Shit	Zie /	Codol	
	es 1 and 2 should b of Health and Ment fitam 27 Is markad ir other traumatic a		Robert R. Ward,								l, Gait					882
Baltimore,	Pages 1 annount of He ant: If itam		20a. Method of Disposition  1 ☐ Burial 2 ②Cremation 3 ☐  1 ☐ Donation 5 ☐ Other (Specify		1	ry, crei	osition (Nam matory or ot .itan	her place			ate 80/05		cation - City exandr			
Balti	permit. Pages Department of Important: If ii any injury or once.		21. Signature of Funeral Service Licen	1, 0	her	22		l H.	Barl	ber E	uneral Laytons				20882	
September 1	Physician /Medical Examiner		23a. Part 1. Enter the disease, or compshock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)	olications that caused one cause on each line a Due to (or a. a.	o wid	lias		of dying	g, such as	cardiac o			•		Approxima Interval Bei Onset and	tween
68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a d.												
P.O. Box 6	it the death certific. by the attending pl tached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at to 9 □ Unknown	Fetal death		⊒Ectopic pre ⊒ Other (spe					2	23d. Date of Month		•	Year
	w requires that been signed b should be deta	by	Part II. Other significant conditions of Reval Far		t not resulting i	n the u	nderlying ca	ause give	n in Part I.			bacco u es 2[	se contribute	to the	-	death? Unknown
I Records,	The law re cate has bee page 2 sho	Completed											24b. Were prior to death	to com ?	sy findings pletion of c	available cause of
Vital	sician: Th certificate rector, pag	Be (	25. Was case referred to medical examiner?								(Check only o					
of	Phys rthis ral dii	lon; To	1  Yes 2 No  27. Manner of Death 1 Natural 5 Pending	Hospital: 1 Inpatier 28a. Date of Injury (Month, Day		utpatier Time of Injury		Bc. Injury Work	4 🗆 140	2	ne 5 PResid 8d. Describe h		Other (S	pecify)		
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		ry · At home, fa (Specify)	arm, str			00 2		8I. Location (S City or Tox			Rural	Route Nun	nber,
	To tha Hospital or Attani within 24 hours after deatl To tha Funeral Diractor: completely filled in by the	edical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best o iner: On the basis of and manner stat	examination ar	e, deat	h occurred a	at the tim in my op	e, date an inion, deat	d place, a	nd due to the old at the time,	cause(s) date and	and manner place, and c	as sta lue to t	ted. the cause(s	s)
	To th within To th compl	Me	29b. Signature and title of certifier				29c.	License		_			e signed (Mo			
•	5+1		▶ Clustople					03	979	3		Ar	orila	191	200	5
			30. Name and address of person who		ath (Item 23a)	(Type,	Print)	110	De.	01	noy, u	w	2083	32		
	Sta Regist		31. Date filed (Month, Day, Year)  MAY 0 2 2005		r's Signature	234		1								

			1 - For State Registrar		larylar		artment of F rtificate of	Health a	and Me	ental Hygi	g. No.	105	15	498
	Physici	an	Decedent's Name (First, Middle, La						2	<ol><li>Date of Death Month</li></ol>	Day	Year	3. Time of	
-	/Medi	cal	ISABEL NIEL WELL							PRIL_	23	2005	2:35	PM
	Examir	ner	4a. Facility Name (If not institution, gine FREDERICK MEMORIA				4b. City, Town, o		of Death		1	nty of Death		
	Funeral		Social Security Number 6. 5	Sex 7. A		last birthday)	If Under 1 Year	If Under 2	24 Hrs.   8	. Date of Birth	FRED	ERICK 9. Birthp	place (State o	or Foreign
	Director		217-01-9070	1□M 2ØF	92	Yrs.	Months Days	Hours	Min.	B. Date of Birth (Month, Day, June 26	,1912	Cour	land	
	pug *		Usual Residence of Decedent  10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation						0d. Inside C	its Limite
	Marylt f sho	JO.	Maryland Frederi	ole.										2 □ No
	the 28e-	rect	10e. Street and Number	-CK		Churmor	10f. Zip Code			10	g. Citizen o	of What Cour	ntrv?	
	172 hours after death with the Maryland "natural", or Iteme 23a or 28e-f show odjest Examiner must be notified at	Funeral Director	17 E.Moser Road				21	788			1	USA		
	eme	iner	11. Marital Status	12. Was Deceden		I.S. 13.	Was Decedent of H	lispanic Orig	gin? (Speci	fy Yes or No-		ace - Americ		
36	s afte	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 <b>X</b> If Yes, Give	] No		1 ☐ Yes 21 No				Spec		White	
8	hour	ed p	3 ☑ Widowed 4 ☐ Divorced  15. Decedent's E	Year or Dates		16a Dece	dent's Usual Occup	ation				Business/In		
15	n "ne n "ne Medic	Completed	(Specify only highest gr Elementary/Secondary (0-12)	ade completed)	. 5 . \	(Give	kind of work done DO NOT use retire	during most	of working	' '	OD. KING OI	DUSITIESS/IN	dustry	
212	filed within it Hygiene.	Com	12	College (1-4or	D+)		Seamstre	SS			Cloth:	ing Ma	nufact	turer
p	0 0 77 2	Be	17. Father's Name (First, Middle, Last							First, Middle, M	aiden Sum	ame)		
yla		2	Clarence Wilson							Elizab				
Maryland 21215-0036	12 sho h and 7 is mu iraum		19a. Informant's Name/Relationship   Sarah Trout Knowl	• • • • • • • • • • • • • • • • • • • •			ng Address <i>(Street</i> Junellen ]						Code)	
d)	s 1 and 2 should f Health and Mer Item 27 Is marke other traumatic		20a. Method of Disposition		20b. I	Place of Dispo	sition (Name of		Dat	1.0		n - City or To	wn State	
Baltimore,	6 O		1 Burial 2 □ Cremation 3 E 4 □ Donation 5 □ Other (Speci		9 (	cemetery, crer	natory or other place e Cemete:	· 1	5/01/2			ont, M		
H	permit. Pag Depertment Important: I any Injury o		21. Signature of Fundal Jervice Lice	1.00	DIC		2. Name and Addre							
Ö	Dep June		+orum()	len -	>		04 East 1							
	Physician /Medical Examiner		23a. Part Enter the disease, or con shock be bear failure. List only limediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	a. Due to (or a	ed the dear line. 19-(7) s a consec wsc/e	quence of):	HeART  CARdio	Failu Vascul	cardiac or r	Pisconial Pisco	st,		Approximate Interval Betto Onset and I	ween
8760,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	dical Examine	if any, leading to immediate cause. Enter Inderlying Cause (Disease or injury that initiated events resulting in death) Last	c.  Due to (or a										
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	w requires that been signed I should be det	by	Part II. Other significant conditions	contributing to death	but not res	ulting in the u	nderlying cause grv	en in Part I.		23e. Did toba	_		e cause of dably	
Vital Records,	The ete h page	Completed								24a. Was an autopsy perform 1 Yes 2		prior to cor death?	psy findings and pletion of ca	
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:						Check only one	)			
of	S S	n; To	1 Yes 2 No 27. Manner of Death	28a. Date of Inj (Month, D	urv	ER/Outpatien 28b. Time of Injury		4 🔲 Nur	-	5 Resider  d. Describe hov			1)	
ior	Attending I r death. ector: After by the funer	atio	1 Natural 5 Pending 2 Accident investigation	n	ay 1 bar)	injury		Yes 2□N	No					
Division	2 2 2 2	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Ir	njury - At h etc. <i>(Specil</i>	ome, farm, str (y)	eet, factory, office		28f	f. Location (Stre City or Town,	et and Nun State)	nber or Rura	l Route Num	ber,
	To the Hospital of within 24 hours at To the Funeral D completely filled it	edical	29a. Certifier (Check only one)	nysician: To the bes miner: On the basis and manner s	of examina	owledge, death	n occurred at the tin vestigation, in my o	ne, date and pinion, death	d place, and h occurred	d due to the cau at the time, dat	ise(s) and n e and place	nanner as st , and due to	ated. the cause(s)	)
	To th within To th	Me	29b. Signature and title of certifier	/			29c. Licens	e number		29	d. Date sign	ed (Month, I	Day, Year)	
			1/796	~ mo			1200	3515	52		4.	25.0	75	
_	7		30. Name and address of person who	5 MB	/	100 5				hurm				1788
	Sta Registr	200	31. Date filed (Month, Day Year) MAY 0 3	2005 32. Ruist	rar's Signa	ature	(mile)							

James L. Windsor Jr. 05-2979 KLB

# Please Type or Print in Black Indelible Ink Ensure All Conies Are Logible

79		For	State of Maryland				•	ienes o o	
		1 - For State Registrar			rtificate of			g. No.	0 1649
Physic	cian	Decedent's Name (First, Middle, Last)					2. Date of Deat Month	Day Yea	
/Med Exam		James Lindsey Wir 4a. Facility Name (If not institution, give	ndsor, Jr.		4b. City. Town. o	or Location of Deat	4-29-0	4c. County of De	2300pm <sup>N</sup>
LAdili	iiiei	19705 Aquasco Rd.			Aguasco	or countries of boat		Prince G	
Funera		5. Social Security Number 6. Sec	44 -07-	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, Day,	Year) 9. E	Firthplece (State or Foreig Country)
Directo		Usual Residence of Decedent	27	113.			Sept. 5	1977 M	aryland
arylan ahow	_	10a. State 10b. County		, Town or Lo	cation				10d. Inside City Limits
the M 28a-f	recto	Maryland Prince G	ieorge's Brai	ndywir	10f. Zip Code		10	g. Citizen of What	1 Yes 2 No
th with 23a or	Funerai Director	1307 Molly Berry R	load		20613			nited Sta	
er dea	uner		<ol> <li>Was Decedent Ever in U.S Armed Forces?</li> </ol>	6. 13.		lispanic Origin? (S an, Mexican, Puen	pecify Yes or No- o Rican, etc.)		nerican Indian,
5-UUSD 72 hours after death with the Maryland natural, or Itams 23a or 28a-f ahow	þ	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 📉 No If Yes, Give Year or Dates:		1 □ Y <i>e</i> s 2 <b>X</b> No	Specify:		Specify:	•
Maryjand ZIZI3-UU30 nd 2 should be filed within 72 hours af lith and Mental Hygiene. 27 is marked other than "natural" or r traumatic avent, the Medicel Eners	Completed	15. Decedent's Edu (Specify only highest grad	cation	16a. Deced	lent's Usual Occup	pation during most of wo	rking	6b. Kind of Busines	ite s/Industry
within iene.	idmo	Elementary/Secondary (0-12)	College (1-4or 5+)	_		during most of word)		0	
ild Z illed illed	Be Co	17. Father's Name (First, Middle, Last)		Lar	penter	18. Mother's Nar	ne (First, Middle, N	Construct aiden Sumame)	:10n
aryian should be nd Mental markad o	To B	James L. Windsor.	Sr.			Jeanne ]	. Windso	r	
DENTITROFE, INIGITY JAING ZIZID-UU30 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-f ahow any injury or other traumatic avant, the Medical Engine must be inclifted at any injury or other traumatic avant, the Medical Engine must be inclifted at once.	1	19a. Informant's Name/Relationship (Ty	. ,					City or Town, State	
re, n s 1 and f Health item 27 othar tr		James L. Windsor, 20a. Method of Disposition	20b. Pla	ace of Dispo	sition (Name of		Brandyw 2	ine, MD 2 0c. Location - City of	0613 or Town, State
Datuilliore, permit. Pages 1 a Department of Hez important: If item any injury or otha		1 M Burial 2 ☐ Cremation 3 ☐ R 1 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	-	atory or other plac ion Ceme		06-2005	Clinton,	Maryland
permit. Departn Importa any inju		21. Signature of Funeral Service License	M01246	22	. Name and Addre	ss of Facility		orrincon,	maryranu
00500		23a. Part 1. Enter the disease, or compli	cations that caused the death	Do not ont	.O. Box 1	156, Wald	orf, MD 2	20604-015	5
- Paysician	L.	Immediate Cause (Final	ie cause on each line.			1	or respiratory arre	51,	Approximate Interval Between Onset and Death
/Medical		disease or condition resulting in death)	Due to (or as a conseque		ue 147	27/83			-
Examiner		Sequentially list conditions,							
uted 1 Insit	Examiner	Sequentially list conditions, if any loading to immediate cause. Enter Underlying Cause (Disease or injury	One to (or as a sonseque	entes oty:					
ate be executed hysician and the burial-transit		that initiated events resulting in death) Last	Due to (or as a conseque	ence of):					
	dicai				-				
ires that the death certificate be executed signed by the attending physician and d be detached for use as the buriat-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	 3c. If yes, outcome of pregnan					23d. Date of d	elivery
death death of for	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 ∏ Fetal of 4 Pregnant at time of dea 9 Unknown		Ectopic pregnancy Other (specify)			Month	Day Year
hat the deby the detache		9 ☐ Unknown  Part II. Dther significent conditions con		ting in the us	darking as use as	an in Daniel	22a Didasha		)
Attending Physician: The law requires that the redain.  sector: After this certificate has been signed by the tuneral director, page 2 should be detached.	d by	Taxiii Sila Sigili Solida Soli	thousing to death but not result	ung in the di	derlying cause give	enin rani.	1 Tyes	1-0	to the cause of death?  Probably 4 Unknown
he law requires t he has been signe tge 2 should be o	Completed						24a. Was an	24b. Were a	utopsy findings available
The lay	Com						autopsy perform 1 Yes 2	prior to death? No Var	
or Attending Physician: The after death.  Diractor: After this certificate his in by the funeral director, page	Be	25. Was case referred to medical examiner?	ospital:		Oth		th Check only one		
Phys or this eral dir	n: To	1 X Yes 2 No ☐	1   Inpatient 2   E	P/Outpatient 28b. Time of	3 □ DOA Othe 28c. Injun Work	4   Nuising	ome 5 Residen		ecify)At scene
Attending Pher death. Sector: After the by the funeral	ation	1 □Natural 5 □ Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	2:44	M 1 🗆			hvelved is	profor velical
	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)		1		28f. Location (Stree City or Town,	et and Nymber or F State) KT 38	Tural Route Number,
To the Hospital or within 24 hours after To the Funeral Director Completely filled in		29a. Certifier 1 ☐ Certifying Phys	icien: To the best of my know	STVER			Aquasco RQ	HALIGSCO	in
To the Hospital within 24 hours a To the Funeral I completely filled	edical	(Check only 2 Medicel Exeminate)	er: On the basis of examination and manner stated.	on and/or inv	estigation, in my of	pinion, death occur	red at the time, dat	se(s) and manner a e and place, and du	s stated. e to the cause(s)
To the Ho within 24 t To the Fu completely	Ž	29b. Signature and title of certifier	2 4 5		29c. License	e number	290	I. Date signed (Mon	th, Day, Year)
		lebrulk	4 AL		OCME		Ap	ril 30, 2	005
B2.		30. Name and address of person who con	mpleted cause of death (Item 2	23a) (Type, F	•				
St	ate	31. Date filed (Month, Day, Year)	32. Figistrar's Signatu	24 1	111 Per	nn Street	: Baltimo:	ce, Maryl	and 21201
Regist	rar	MAY 0 3 20	UU Marian 1	19					

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3, Time of Death **Physician** April 2005 23 11:15 a Donald Clinton Whitaker, Sr /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll 48 Falling Leaf Court Westminster If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) August 23 1934 Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1**∑** M 2□ F 230-40-5121 70 Yrs Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r then "neturel", or items 23e or 28e-f show the Mcdical Examinational be notified at Salem Salem VΆ 1 ☐Yes 2 ☐ No Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 24153 USA 3704 McDaniel Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 ☐ Yes 2 ☐ Xo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify: Specify: ģ 3X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry pes 1 and 2 should be filed within 7 of Health and Mental Hygiene. If item 27 is marked other then "n or other treumatic event, I'le Med College (1-4or 5+) Elementary/Secondary (0-12) Self Employed Electrician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked cety injury or other treumatic ew ones. Mildred Tabor David Whitaker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 5317 Hampton Forest Way Fairfax, Va 2203 19a. Informant's Name/Relationship (Type, Print) Donald C. Whitaker, Jr/son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Carroll Cremation, Inc 5/3/2005 Hampstead, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Britts Aftimeration Home and Chapel, P.A. 412 Washington Road Westminster, MD 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pharyngea Physician Carcinoma Years /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine certificate be executed Due to (or as a consequence of): attending physician a for use as the burial-Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 3 robably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed) this certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Cther: 4 Nursing Home 5 Residence 6 Hother (Specify ers Residence 10 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After funera Natural 5 Pending 1 ☐ Yes 2 ☐ No hours after death. investigation 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 TSuicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ō 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and tyle of certifier 29c. License number 29d. Date signed (Month, Day, Year) WIL D0051924 May 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Registra

31. Date filed (Month, Day, Year)

MAY 0 2 2005

Herbert P. Handerson Jang 2973 Manchester RJ Monchester 32. Registar's Signature